

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5400

County CarrollVillage or City Crisfield Md (No. _____, St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John T. Bane

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH Feb 29, 1884
(Month) (Day) (Year)

7 AGE 70 yrs. 3 mos. 21 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) W.Va.

PARENTS
10 NAME OF FATHER Jesse Bane
11 BIRTHPLACE OF FATHER (State or country) W.Va.
12 MAIDEN NAME OF MOTHER Don Kramm
13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Bane(Address) Crisfield Md

15 Filed June 19, 1914 L. M. Caraway M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1914, to June 19, 1914, that I last saw him alive on June 19, 1914.

and that death occurred on the date stated above, at 4.45 a.m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(Duration) ? yrs. ____ mos. ____ ds.

Contributory Tetanus Secondary

(Duration) ? yrs. ____ mos. ____ ds.

(Signed) L. M. Caraway M.D., M. D.June 19, 1914 (Address) Crisfield Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Crisfield Md DATE OF BURIAL June 19, 191420 UNDERTAKER John C. Welford ADDRESS Cumberland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

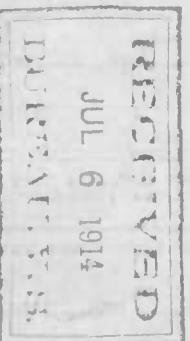
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5401

County

Village or City

Allegheny
near Cumberland (No. *Valley Road*)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *14*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Bias

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Don't know

(Month)

(Day)

1914

(Year)

7 AGE

6

yrs.

mos.

ds.

It LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Moorefield W. Va.

PARENTS

10 NAME OF FATHER

Chas. Bias

11 BIRTHPLACE OF FATHER (State or country)

Springfield W. Va.

12 MAIDEN NAME OF MOTHER

Mary Taylor

13 BIRTHPLACE OF MOTHER (State or country)

Moorefield W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Bias

(Address)

Cumberland and 7th

15

Filed

*JUN 29 1914**Ralph R. Bias*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 27

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191...., to

191....,

that I last saw him alive on

191....,

and that death occurred on the date stated above, at *7:00* m.

The CAUSE OF DEATH* was as follows:

Syphilis

(Duration)

yrs. *6*

mos.

ds.

Contributory
Secondary*Marasmus*

(Duration)

yrs.

mos.

ds.

(Signed)

Ralph R. Bias

M. D.

7/29

1914

(Address)

Cumberland

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Allegheny County**4-21*, 1914

20 UNDERTAKER

ADDRESS

*G. S. Butcher**city*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

9

Bd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5402
 County Allegheny (S)
 Village or City Cumberland (No. 12, S. Cedar St.; 6 Ward)
 2 FULL NAME Burley Stillborn
 Registration Dist. No. 4
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE White
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)
 6 DATE OF BIRTH June 28, 1914
 (Month) (Day) (Year)
 7 AGE Still Born
 yrs. mos. ds. OR min. ?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Cumberland, Md.

10 NAME OF FATHER Chas Bowley
 11 BIRTHPLACE OF FATHER (State or country) Morgan Co W. Va
 12 MAIDEN NAME OF MOTHER Jedah Northeast
 13 BIRTHPLACE OF MOTHER (State or country) Allegheny Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Bowley

(Address) 12 S. Cedar St

15 June 29 1914
 REGISTRAR Joseph R. Davis

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h_____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m,
 The CAUSE OF DEATH* was as follows:

Still Born.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. P. Burdette, M. D.
June 29, 1914 (Address) Cumberland Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Rose Hill Ave June 29 1914
Louis Steen City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

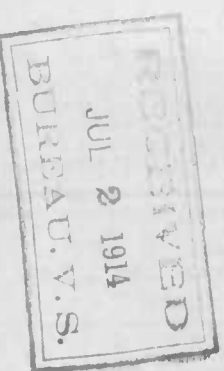
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1 PLACE OF DEATH 5403

County

Allegheny

Village or City

Lord

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 12

2 FULL NAME

William Henry Boyce

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June 9, 1883

7 AGE

31

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Frostburg Md

PARENTS

10 NAME OF FATHER

Wm H Boyce

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Eliza Price

13 BIRTHPLACE OF MOTHER

(State or country)

Mt Savage Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elsworth Boyce

(Address)

Lord Md

15

Filed

June 10, 1914

J. H. Charles

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 9, 1914, to June 10, 1914,

that I last saw him alive on June 10, 1914,

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Fracture 3" of 4th Dorsal vertebra — Mine Accident

(Duration) yrs. mos. 1 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. Charles

M. D.

June 10, 1914 (Address) Midland Md

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frostburg Md

June 12, 1914

20 UNDERTAKER

ADDRESS

J. J. Dush

Frostburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

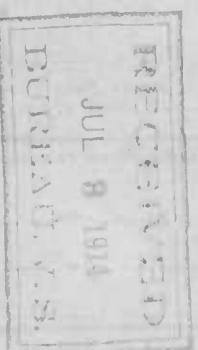
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH County <u>Allegany</u> Village or City <u>Cumberland</u> (No. <u>Allegany Hosp.</u>) Ward <u>st</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>st</u> | |
| 2 FULL NAME <u>Joseph H. Brooks</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married.</u> (Write the word) | |
| 6 DATE OF BIRTH <u>Aug 28</u> , 18 <u>74</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>40</u> yrs. <u>9</u> mos. <u>21</u> ds. | | It LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Driver</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Coal Cart.</u> | | | |
| 9 BIRTHPLACE (State or country) <u>md.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Nathaniel Brooks</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>md.</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Lillie Tawny</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>ms.</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Fannie Brooks</u> (Address) <u>Hornhoffs Alley</u> | | | |
| 15 Filed <u>JUN 9 1914</u> <u>Joseph L. Baird</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 8</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 4</u> , 191 <u>4</u> , to <u>June 8</u> , 191 <u>4</u> that I last saw him alive on <u>June 7</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>7 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Lock-jaw (Tetanus)</u> | | | |
| Contributory (Duration) yrs. mos. <u>5</u> ds. Secondary <u>Nail wound of foot</u> (Duration) yrs. mos. <u>21</u> ds. | | | |
| (Signed) <u>J. Swisher</u> , M. D. <u>June 8</u> 191 <u>4</u> . (Address) <u>Cumberland, ms.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>4</u> ds. In the State <u>40</u> yrs. <u>9</u> mos. <u>21</u> ds. Where was disease contracted, <u>Hornhoffs Alley.</u> If not at place of death? Former or usual residence <u>Hornhoffs Alley</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Summer Creek</u> | | DATE OF BURIAL <u>June 10</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>Louis Stein City.</u> | | ADDRESS | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 9

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

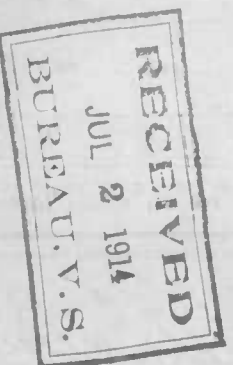
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

5405

County AlleganySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 14Village or City Cumberland (No. 146 Fredrick St. 4 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Martha Burgee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

Dec. 16, 1845
(Month) (Day) (Year)

7 AGE

68 yrs. 6 mos. 4 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Housewife(b) General nature of Industry, business, or establishment in which employed (or employer) Home9 BIRTHPLACE
(State or country)Md.

PARENTS

10 NAME OF FATHER

John S. Brown11 BIRTHPLACE OF FATHER
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Eliza Qusen13 BIRTHPLACE OF MOTHER
(State or country)Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredrick Burgee(Address) 146 Fredrick St.

15

JUN 22 1914 Ralph P. Baird
Filed 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 20th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

May 17th, 1914, to June 20th, 1914
that I last saw h. alive on June 19th, 1914and that death occurred on the date stated above, at 1-309 m.

The CAUSE OF DEATH* was as follows:

Myocardial InfarctionContributory
SecondaryEndocarditis
(Duration) 1 yrs. 3 mos. 3 ds.(Duration) 1 yrs. 10 mos. 10 ds.(Signed) Spurgeon Stanley, M. D.June 22, 1914 (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sumner Cem.

DATE OF BURIAL

June 23, 1914

20 UNDERTAKER

Louis Stein

ADDRESS

City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

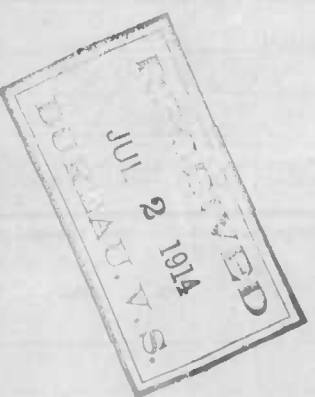
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5406

County AlleghenyVillage or City Cumberland (No. 201, Grand Ave., St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 14

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME MARY SUSAN CASTLE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH May 25, 1865
(Month) (Day) (Year)

7 AGE 49 yrs. 0 mos. 9 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Milliner
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9 BIRTHPLACE (State or country) West Virginia

10 NAME OF FATHER Peter G. Peters

11 BIRTHPLACE OF FATHER (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Catherine Davis

13 BIRTHPLACE OF MOTHER (State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Castle

(Address) Cumberland, Md.

15 June 6 1914 1914 Joseph P. Dwyer
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1914, to June 3, 1914.

that I last saw her alive on June 3, 1914 and that death occurred on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 1/4 hrs. mos. ds.

Contributory
Secondary

(Duration) 1/4 hrs. mos. ds.

(Signed) C. L. Dwyer, M. D.
June 4, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Rose Hill DATE OF BURIAL June 6, 1914

20 UNDERTAKER Louis Stern ADDRESS City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

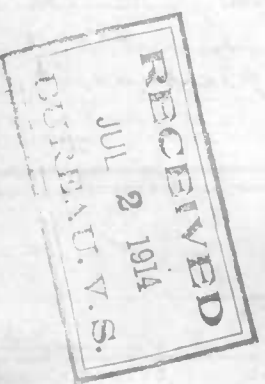
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH County <u>Allegany</u> Village or City <u>near Corriugville</u> (No. <u>Wills Creek</u>) | | STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>4</u> | |
| 2 FULL NAME <u>Henry W. Clites</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | |
| 6 DATE OF BIRTH <u>Oct 25, 1892</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>21</u> yrs. <u>8</u> mos. <u>3</u> ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Glassworker</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Pa.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Henry Clites Sr.</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Don't know</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Caroline Bruck</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Pa.</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Fredrick W. Dreyer</u> (Address) <u>2 S. Main St.</u> | | | |
| 15 Filed <u>JUL 1 1914</u> , 191 <u>4</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 28</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from, 191....., to , 191..... that I last saw h..... alive on , 191..... and that death occurred on the date stated above, at <u>3 P</u> m. The CAUSE OF DEATH* was as follows: <u>Strained - accidental</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>Wm. H. Shaw</u> Coroner, M. D. <u>June 28</u> , 191 <u>4</u> . (Address) <u>Cumtobut road</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>1</u> ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence <u>#2 Lybourn Ave</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Old Little Creek Church</u> | | DATE OF BURIAL <u>July 1, 1914</u> | |
| 20 UNDERTAKER <u>Louis Jones</u> | | ADDRESS <u>City</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

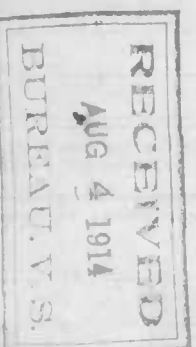
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5408

County

Allegheny

Village or City

Eckhart

(No.)

St.; Ward)

Registration Dist. No. 19

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Corvey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept. 4, 1872

(Month) (Day) (Year)

7 AGE

41

8 yrs. 8 mos. 29 ds.

If LESS than 1 day, hrs. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

Mine (Coal)

9 BIRTHPLACE

(State or country)

Eckhart

PARENTS

10 NAME OF FATHER

Peter Corvey

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Annie Blake

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Corvey, Jr.

(Address)

Eckhart

15

Filed

June 4, 1914 D. J. L. Corvey

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 3, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, that I attended deceased from

Feb

June 3, 1914

that I last saw him alive on June 3, 1914

and that death occurred on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. — mos. — ds.

Contributory
Secondary

Alcoholism

(Duration) 2 yrs. — mos. — ds.

(Signed)

D. J. L. Corvey

M. D.

June 4, 1914

(Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Michael Cemetery June 5, 1914

20 UNDERTAKER

ADDRESS

Frostburg Fur Co Frostburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

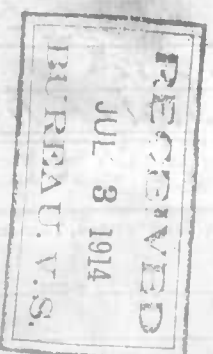
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name of organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5409

County

Allegheny

Village or City

Cumberland (No. 66, Cumberland St., Ward)

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Copeland Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

June 10, 1914

7 AGE

If LESS than

1 day, ____ hrs.

____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Cumberland Md.

PARENTS

10 NAME OF FATHER

C. L. Copeland

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

May Schaffer.

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. H. P. Copeland.

(Address)

Blaine, W. Va.

15 JUN 11 1914

Filed

191

Ralph C. Burt

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

____, 191____, to ____

____, 191____.

that I last saw him alive on ____

____, 191____.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Born dead

Still Born

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. P. Copeland, M. D.

June 11, 1914 (Address) Blaine, W. Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill

6/12, 1914

20 UNDERTAKER

G. S. Butler

City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

5410

175

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 4

County AlleganyVillage or City Cumberland (No. Allegany Hos St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joseph Straight Craighead

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasoid5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the status)Single

6 DATE OF BIRTH

unknown, 1890
(Month) (Day) (Year)

7 AGE

24 yrs. — mos. — ds. OR 1 day, — hrs. — min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Pa

10 NAME OF FATHER

don't know

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)—

12 MAIDEN NAME OF MOTHER

—13 BIRTHPLACE OF MOTHER
(State or country)—

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allegany Hospital

(Address)

Cumberland Md

15

JUN 4 1914

Joseph L Craighead

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 2, 1914, to June 2, 1914.that I last saw him alive on June 2, 1914and that death occurred on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Camp foot Right leg
from R.R. injury Run over
by train
(Duration) yrs. 1 mos. — ds.Contributory
Secondary(Duration) yrs. — mos. — ds.(Signed) E. B. Claybrook, M. D.June 3, 1914. (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. 1 ds. In the about 1 year State — yrs. — mos. — ds.Where was disease contracted, If not at place of death? Cumberland MdFormer or usual residence Chicago Ill.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Allegany Cemetery June 4, 1914

20 UNDERTAKER

ADDRESS

Louisa St. City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 5411

County AlleghenyVillage or City Cumberland (No. 22, Lang Ave St.; 6 Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rebecca J. Crist

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH

Mar 14, 1856
(Month) (Day) (Year)

7 AGE

58 yrs. 2 mos. 27 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

9 BIRTHPLACE

(State or country)

Vo

PARENTS

10 NAME OF FATHER

Johnathon Crist

11 BIRTHPLACE OF FATHER

(State or country)

Va

12 MAIDEN NAME OF MOTHER

Sallie Frank

13 BIRTHPLACE OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. K. Crist

(Address)

22 Lang Ave City

15

Filed

JUN 12 1914

191

Wm. R. Crist
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 11, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 20, 1914, to June 11, 1914.that I last saw her alive on June 11, 1914.and that death occurred on the date stated above, at 7:46 P. m.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart
acute myocarditis
following rheumatism
(Duration) yrs. 6 mos. ds.Contributory
SecondaryCh

(Duration) yrs. mos. ds.

(Signed) William R. Goard, M. D.June 11, 1914 (Address) Cumberland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Broadway Va June 13, 1914

20 UNDERTAKER

ADDRESS

Louis Steen June 13 '14

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

9

W. R. Crist

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

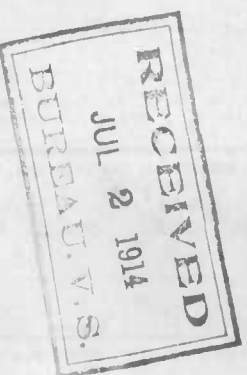
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5412

County

Alleghany

Village or City

Ocean

(No.

St;

Ward)

Registration Dist. No.

12

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

married

6 DATE OF BIRTH

August 15th, 1840

7 AGE

73

yrs.

9

mos.

26

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

miner (coal)

(b) General nature of industry,
business, or establishment in
which employed (or employer)

coal miner

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

John Cunningham

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

C

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Patrick Cunningham

(Address)

Ocean, Maryland

15

Filed

June 11, 1914

F. H. Parker

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 11th

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

December 13, 1913, to June 11th, 1914

that I last saw him alive on

June 11th, 1914

and that death occurred on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration)

7

mos.

3

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

M. J. Mc Dermott

M. D.

June 11, 1914

(Address)

Midland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frostburg Md

June 13, 1914

20 UNDERTAKER

ADDRESS

J. J. Dunt

Frostburg Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

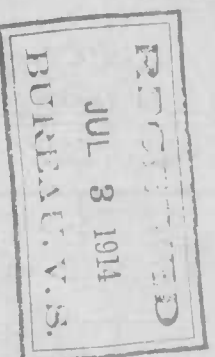
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5413

County Allegheny andVillage or City Cumberland (No. 42, Oldtown Rd., St. _____ Ward _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 24

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME LEONA V. CURTIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH August 6, 1866
(Month) (Day) (Year)

7 AGE 47 yrs 8 mos. 28 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER James Jevos

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Brodes

13 BIRTHPLACE OF MOTHER (State or country) virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed. Curtis(Address) Cumberland, Md.

15 JUN 5 1914
Filed _____, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from June 2, 1914, to June 3, 1914, that I last saw her alive on June 3, 1914

and that death occurred on the date stated above, at 11:50 p.m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Contributory
Secondary

(Signed) R. D. TREVASKIS, M. D.
June 4, 1914. (Address) 27 Green St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Winchester, Va. DATE OF BURIAL 6/5, 1914

20 UNDERTAKER James H. Hines ADDRESS Cum gratia

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH 5414 | | STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 4 | |
| County Alleghany | | | |
| Village or City Cumberland (No. Alleghany Hospital St.; Ward) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME Infant of R W Davis | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single | |
| 6 DATE OF BIRTH June 3, 1914 (Month) (Day) (Year) | | | |
| 7 AGE yrs. mos. 20 ds. | | If LESS than 1 day.....hrs. OR.....min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) W. Va | | | |
| PARENTS | 10 NAME OF FATHER R W Davis | | |
| | 11 BIRTHPLACE OF FATHER (State or country) W. Va | | |
| | 12 MAIDEN NAME OF MOTHER Anna Zimmerman | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) W. Va | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) R. W. Davis (Address) Cass Davis Ave | | | |
| 15 | | 16 DATE OF DEATH June 22, 1914 (Month) (Day) (Year) | |
| 17 | | I HEREBY CERTIFY, That I attended deceased from June 20, 1914 , to June 22, 1914 , that I last saw her alive on June 20, 1914 , and that death occurred on the date stated above, at 50 m. | |
| The CAUSE OF DEATH* was as follows: Arterial Brist 7 rect. | | | |
| Contributory Secondary Exhaustion (Duration) yrs. mos. ds. | | | |
| (Signed) Thos. H. Ford , M. D. June 23, 1914 (Address) Greenbriar | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death Alleghany Hospital yrs. mos. ds. State W. Va yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence Marquette W. Va | | | |
| 19 PLACE OF BURIAL OR REMOVAL Ross Hill | | DATE OF BURIAL June 23, 1914 | |
| 20 UNDERTAKER J. C. Wolford | | ADDRESS Cumberland | |
| REGISTRAR Joseph T. Bird If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

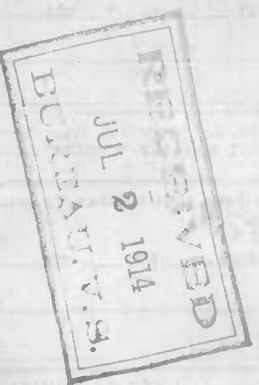
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | |
|--|---------------------------------|---|--|--|--|---|--|
| 1 PLACE OF DEATH | | 5415 | | 76 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Alleg</u> | | Village or City <u>Cumberland</u> | | (No. <u>T B Sanitorium</u> St. <u>Ward</u>) | | Registration Dist. No. <u>4</u> | |
| 2 FULL NAME <u>Elizabeth Garrison</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Divorced</u> (Write the word) | | | | | |
| 8 DATE OF BIRTH <u>June 11, 1885</u> (Month) (Day) (Year) | | 7 AGE <u>29</u> yrs. <u>0</u> mos. <u>3</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 9 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | 16 DATE OF DEATH <u>June 14, 1914</u> (Month) (Day) (Year) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Ma</u> | | 17 I HEREBY CERTIFY, That I attended deceased from, 191....., to 191..... that I last saw h..... alive on 191..... and that death occurred on the date stated above, at <u>6 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lung</u> (Duration) <u>1</u> yrs. mos. ds. | | | | | |
| 10 NAME OF FATHER <u>B. E. Traven</u> | | Contributory Secondary (Duration) yrs. mos. ds. | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>W. Va.</u> | | (Signed) <u>John H. Ford, M. D.</u> <u>June 15, 1914</u> (Address) <u>Cumberland</u> | | | | | |
| 12 MAIDEN NAME OF MOTHER <u>Sarah White</u> | | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u> | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>1</u> mos. <u>17</u> ds. In the State <u>29</u> yrs. <u>9</u> mos. <u>8</u> ds. Where was disease contracted, If not at place of death? <u>Cumberland</u> Former or usual residence <u>515 Springdale St.</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R. H. Traven</u> (Address) <u>Cumberland</u> | | 19 PLACE OF BURIAL OR REMOVAL <u>St. Paul's Church</u> DATE OF BURIAL <u>June 16, 1914</u> | | | | | |
| 15 FILED <u>JUN 15 1914</u> 191 | | 20 UNDERTAKER <u>Louis Steen</u> ADDRESS <u>City</u> | | | | | |
| 16 REGISTRAR <u>Ralph R. Buel</u> | | If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | |
| 228. R. R. S. | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

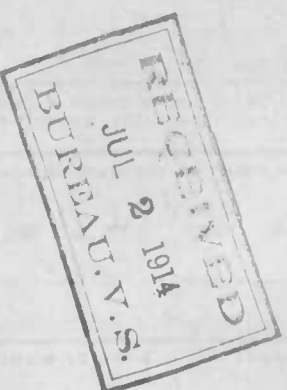
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæ- mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio- lent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci- dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Nomencla- ture of death approved by Committee on Nomencla- ture of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5416
 County Allegheny 109
 Village or City Luke (No. _____, St.; _____ Ward)
 2 FULL NAME Carrie Helen Dick [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---|--|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
| 6 DATE OF BIRTH <u>May 6, 1891</u> (Month) (Day) (Year) | | |
| 7 AGE <u>23</u> yrs. <u>1</u> mos. <u>27</u> ds. | | If LESS than 1 day, _____ hrs. OR _____ min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>clerk</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) <u>West Va.</u> | | |
| PARENTS | 10 NAME OF FATHER <u>Sam'l. A. Dick</u> | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>W. Va.</u> | |
| | 12 MAIDEN NAME OF MOTHER <u>Annie E. Shumaker</u> | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>W. Va.</u> | |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam'l. A. Dick

(Address)

Luke W. Va.

15

Filed

June 29, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

| | |
|--|--|
| 16 DATE OF DEATH <u>June 28, 1914</u> (Month) (Day) (Year) | 17 I HEREBY CERTIFY, That I attended deceased from <u>June 24, 1914, to June 28, 1914</u> that I last saw her alive on <u>June 28, 1914</u> and that death occurred on the date stated above, at <u>2:00 P. M.</u> The CAUSE OF DEATH* was as follows: <u>Peritonitis</u> <u>Obstruction of Bowels</u> <u>OW</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>D. J. Kellum</u> , M. D. <u>June 29, 1914</u> (Address) <u>Richmond, W. Va.</u> |
|--|--|

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. in the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

| | |
|--|--|
| 19 PLACE OF BURIAL OR REMOVAL <u>Richmond, W. Va.</u> | DATE OF BURIAL <u>June 30, 1914</u> |
| 20 UNDERTAKER <u>Mr. Dick Lock</u> | ADDRESS <u>Richmond, W. Va.</u> |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

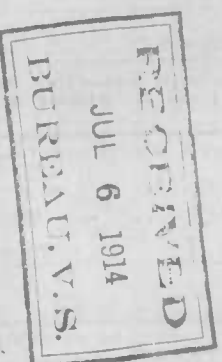
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person. Irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5417

County

Allegheny

Village or City

Lonaconing (No. 151)

St.; Ward

[If death occurred to a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Dohm

Registration Dist. No. 8

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June 1st, 1914
(Month) (Day) (Year)

7 AGE

20 yrs. mos. ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Lonaconing MD

PARENTS

10 NAME OF FATHER

Jesse D. Dohm

11 BIRTHPLACE OF FATHER (State or country)

Lonaconing MD

12 MAIDEN NAME OF MOTHER

Bertha Dohm

13 BIRTHPLACE OF MOTHER (State or country)

Lonaconing MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jesse D. Dohm

(Address)

Lonaconing

15

Filed

June 22, 1914

J. B. Suckack
REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 21st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1914, to June 21st, 1914, that I last saw him alive on June 21st, 1914, and that death occurred on the date stated above, at 5-30 a.m.

The CAUSE OF DEATH* was as follows:

Infantile Coarctation due to premature birth.

(Duration) yrs. mos. ds. 20 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. B. Skilling

M. D.

June 22, 1914. (Address) Lonaconing

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Old Cemetery Lonaconing

June 22, 1914

20 UNDERTAKER

ADDRESS

G. E. Spurr & Co

Lonaconing

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

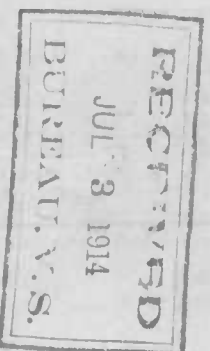
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | |
|---|--|--|---------|-------------------------------|--|--------------------------|--|
| 1 PLACE OF DEATH | | 5418 | | 39 | | STATE OF MARYLAND | |
| County | | Allegany | | | | CERTIFICATE OF DEATH | |
| Village or City | | Cumberland | | (No. 149, N Centre St.; Ward) | | Registration Dist. No. 4 | |
| 2 FULL NAME | | John W. Dorsey | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | | | |
| Male | White | Married | | | | | |
| 6 DATE OF BIRTH | | 1844 | | | | | |
| | | (Month) (Day) (Year) | | | | | |
| 7 AGE | | If LESS than 1 day, hrs. OR min. ? | | | | | |
| 70 yrs. — mos. — ds. | | | | | | | |
| 8 OCCUPATION | | (a) Trade, profession, or particular kind of work | | | | | |
| | | None | | | | | |
| | | (b) General nature of Industry, business, or establishment in which employed (or employer) | | | | | |
| | | — | | | | | |
| 9 BIRTHPLACE (State or country) | | Md. | | | | | |
| PARENTS | 10 NAME OF FATHER | | Unknown | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | | " | | | | |
| | 12 MAIDEN NAME OF MOTHER | | Kerns | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | | Unknown | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | | | |
| (Informant) C. B. Freshour. | | | | | | | |
| (Address) 149 N Centre St. | | | | | | | |
| 15 JUN 16 1914 | | 1914 | | | | | |
| Filed | | 1914 | | | | | |
| REGISTRAR | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH June 15, 1914 | | | | | | | |
| (Month) (Day) (Year) | | | | | | | |
| 17 I HEREBY CERTIFY, that I attended deceased from May 15, 1914, to June 15, 1914. | | | | | | | |
| that I last saw him alive on June 15, 1914 | | | | | | | |
| and that death occurred on the date stated above, at 20 m. | | | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | | | |
| Epithelioma of lower lip | | | | | | | |
| (Duration) 3 yrs. — mos. — ds. | | | | | | | |
| Contributory | | | | | | | |
| Secondary | | | | | | | |
| (Signed) Edward Harris, M. D. | | | | | | | |
| 6/15/14, 1914 (Address) Cumberland, Md. | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | | | |
| At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds. | | | | | | | |
| Where was disease contracted, If not at place of death? | | | | | | | |
| Former or usual residence | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL | | | | | | | |
| Trenches Station June 16, 1914 | | | | | | | |
| 20 UNDERTAKER ADDRESS | | | | | | | |
| Louis Stein Cumberland | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

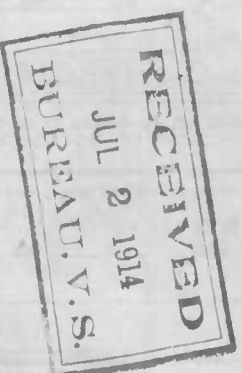
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

5419

County AlleganyVillage or City Cash Valley

(No. _____)

St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME JOSEPH DRESSMAN

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH May 12, 1855
(Month) (Day) (Year)

7 AGE 59 yrs. 0 mos. 22 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) West Virginia

10 NAME OF FATHER Bernard Dressman

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wundstreet

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Dressman(Address) Cash Valley, Md.,

15

Filed June 6, 1914 P. G. Murray Reg.
20 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1914, to June 3rd, 1914.

that I last saw him alive on May 30, 1914.and that death occurred on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
regional metastasis
dissection - Pericardial
effusion (Duration) 1 yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) J. J. Seggs, M. D.
1914 (Address) Chesapeake

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter & Paul's June 6, 1914
20 UNDERTAKER Lonis Stein Cumby Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

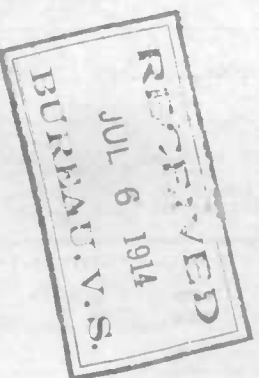
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 5420 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>allegany</u> | | Registration Dist. No. <u>12</u> | |
| Village or City <u>Gulmore</u> (No. <u>173</u>) | | St.; Ward | |
| 2 FULL NAME <u>David W. Edwards</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | |
| 6 DATE OF BIRTH <u>March 11, 1876</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>38</u> yrs. <u>3</u> mos. <u>9</u> ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Miner</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>James Edwards</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>England</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth Jones</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>South Wales</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Mack Marline</u> (Address) <u>Lonsconing Ind.</u> | | | |
| 15 Filed <u>June 21, 1914</u> <u>A. H. Charles</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 20, 1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred on the date stated above, at <u>9 a</u> m. The CAUSE OF DEATH* was as follows: <u>Crushed by a fall of</u> <u>slate + coal.</u> <u>miner accident</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) <u>Wm. A. Shaw, M. D.</u> <u>June 20, 1914</u> (Address) <u>Carmichael and</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, It not at place of death? _____ Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Old Covey Cemetery</u> | | DATE OF BURIAL <u>June 22, 1914</u> | |
| 20 UNDERTAKER <u>M. E. Echols</u> | | ADDRESS <u>Lonsconing Ind.</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

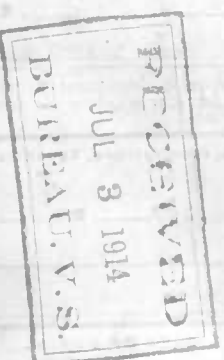
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. If or many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 5421 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Allegany</u> | | Registration Dist. No. <u>10</u> | |
| Village or City <u>McHenry</u> (No. _____) St. _____ Ward _____ | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Austin Elliot</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word) | |
| 6 DATE OF BIRTH <u>Dec 17, 1911</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>2</u> yrs. <u>5</u> mos. <u>20</u> ds. | | If LESS than 1 day, _____ hrs. OR _____ min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Ind</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Clifton Elliot</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Mary C Lynch</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clifton Elliot</u> (Address) <u>Ind Saraghdah</u> | | | |
| 15 Filed <u>June 7, 1914</u> <u>F. A. G. Murray</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 6, 1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 4, 1914</u> , to <u>June 6, 1914</u> , that I last saw him alive on <u>June 6, 1914</u> , and that death occurred on the date stated above, at <u>5 p. m.</u> The CAUSE OF DEATH* was as follows: <u>Surgical Eclampsia</u> | | | |
| (Duration) _____ yrs. _____ mos. <u>2</u> ds. | | | |
| Contributory Secondary <u>Exhaustion</u> | | | |
| (Duration) _____ yrs. _____ mos. _____ ds. | | | |
| (Signed) <u>F. A. G. Murray</u> , M. D. <u>June 6, 1914</u> (Address) <u>Ind Saraghdah</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Ind Saraghdah</u> | | DATE OF BURIAL <u>June 7, 1914</u> | |
| 20 UNDERTAKER <u>Jacob L. Hoff</u> | | ADDRESS <u>Franklin St.</u> | |

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

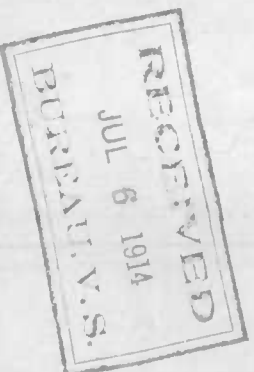
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5422
 County Allegheny (No. 9)
 Village or City McSavage (No. _____, St.; _____ Ward)
 2 FULL NAME George James Elliot
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 10

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH July 13, 1907
 (Month) (Day) (Year)

7 AGE 6 yrs. 11 mos. 21 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
 10 NAME OF FATHER Clifton Elliot
 11 BIRTHPLACE OF FATHER (State or country) Pa.
 12 MAIDEN NAME OF MOTHER Mary C. Lynch
 13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Clifton Elliot
 (Address) McSavage

15 Filed June 23, 1914 F. A. E. Mumay
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1914, to June 22, 1914, that I last saw him alive on June 22, 1914

and that death occurred on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) _____ yrs. _____ mos. 5 ds.
 Contributory Secondary Toxemia

(Signed) F. A. E. Mumay, M. D.
June 23, 1914 (Address) McSavage

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL McSavage DATE OF BURIAL June 23, 1914
 20 UNDERTAKER Jacob H. Hager ADDRESS Frostburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

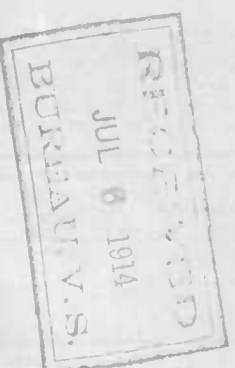
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5423

County AlleganyVillage or City Frostburg (No. 9)Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sara Eutter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH July 7, 1911

(Month) (Day) (Year)

7 AGE 2 yrs. 6 mos. 6 ds.If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS

10 NAME OF FATHER Geo. Eutter11 BIRTHPLACE OF FATHER (State or country) Ind.12 MAIDEN NAME OF MOTHER Elsie Robinson13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Eutter(Address) Frostburg Md

15

Filed June 15, 1914REGISTRAR DeputySTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 14, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from death 1914 to June 13, 1914that I last saw him alive on 6-13, 1914and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Gangrene - feet

(Duration) yrs. mos. ds.

Contributory Secondary Septicemia

(Duration) yrs. mos. ds.

(Signed) W. D. Eutter, M. D.
6-13, 1914 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Blocker CemeteryDATE OF BURIAL June 16, 191420 UNDERTAKER Frostburg Furniture & Undertaking Co.

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

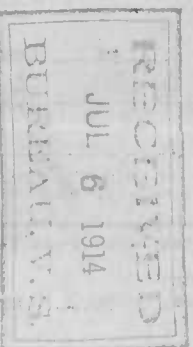
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Toxæmic pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Spasmodic," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5424

County

Allegheny

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

7

Village or City

Barton

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Florence Viola Facebaker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Aug 4, 1913
(Month) (Day) (Year)

7 AGE

10 yrs. 5 mos. 5 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Arthur Facebaker

11 BIRTHPLACE OF FATHER (State or country)

Garrett Co Md

12 MAIDEN NAME OF MOTHER

Ellie K. Facebaker

13 BIRTHPLACE OF MOTHER (State or country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Facebaker

(Address)

Barton

15

Filed

June 10, 1914 D. S. Boucher

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 9, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 9, 1914 to June 9, 1914

that I last saw her alive on June 9, 1914

and that death occurred on the date stated above, at 11-30 p.m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis
Saw the child but a short time before death

(Duration) yrs. 4 mos. 4 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

D. A. Boucher, M. D.

June 10, 1914 (Address) Barton, Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marian's Cem. Ally. Co

June 10, 1914

20 UNDERTAKER

ADDRESS

D. S. Boral

Barton

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

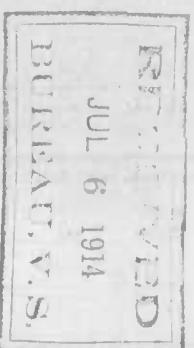
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH 5425 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Allegany</u> | | Registration Dist. No. <u>11</u> | |
| Village or City <u>Edinburg</u> (No. <u>8</u>) | | St.; Ward | |
| 2 FULL NAME <u>Olga Falbo</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>F.</u> | 4 COLOR OR RACE <u>W.</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | |
| 6 DATE OF BIRTH <u>5-29-1914</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>21</u> yrs. <u>21</u> mos. <u>21</u> ds. OR <u>21</u> min. ? If LESS than 1 day, hrs. | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> | | | |
| 9 BIRTHPLACE (State or country) <u>Edinburg, Pa.</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Louis Falbo</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Castiliani Benelli</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Italy</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Louis Falbo</u> (Address) <u>Edinburg, Pa.</u> | | | |
| 15 Filed <u>1914</u> | | | |
| REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>6-19-1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 13th</u> , 1914, to <u>June 19th</u> , 1914, that I last saw him alive on <u>June 18th</u> , 1914, and that death occurred on the date stated above, at <u>11 a.m.</u> The CAUSE OF DEATH* was as follows: <u>Whooping Cough</u> (Duration) <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. | | | |
| Contributory Secondary (Signed) <u>J. C. Coker</u> M. D. <u>June 18th</u> , 1914 (Address) <u>Frederick, Md.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. In the State <u>7</u> yrs. <u>7</u> mos. <u>7</u> ds. Where was disease contracted, If not at place of death? Former or usual residence. | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Frederick</u> | | DATE OF BURIAL <u>June 20, 1914</u> | |
| 20 UNDERTAKER <u>Jacob Baker</u> | | ADDRESS <u>Frederick</u> | |

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

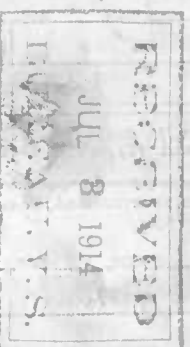
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 5426
 County Allegheny
 Village or City Cumberland (No. W. Md. Hosp. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Clara Fisher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)
6 DATE OF BIRTH — — — 1855
 (Month) (Day) (Year)
7 AGE 59 yrs. — mos. — ds. OR min. ?
8 OCCUPATION
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) Home
9 BIRTHPLACE (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Fisher
 (Address) Westport, Md.

15 Filed JUN 17 1914 Joseph R. Lind
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 17, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1914, to June 17, 1914.

that I last saw he alive on June 17, 1914.

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver & gall-bladder

(Duration) 1 yrs. 1 mos. 1 ds.
 Contributory Shock following oper-
 Secondary ation

(Signed) W. R. Hodges, M. D.
June 17, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 5 yrs. 5 mos. 5 ds. in the Unknown State — yrs. — mos. — ds.

Where was disease contracted, Westport, Md.

It not at place of death? Former or usual residence Westport, Md.

19 PLACE OF BURIAL OR REMOVAL Piedmont, Md. **DATE OF BURIAL** June 17, 1914

20 UNDERTAKER Louis Steen **ADDRESS** City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

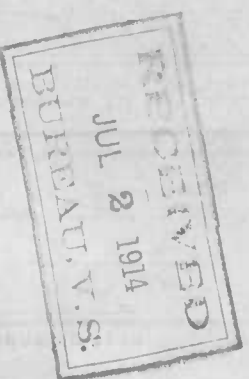
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5427

County

Allegheny

Village or City

Lonaconing

(No.

64

St.:

Ward)

Registration Dist. No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

George Foote

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widower

6 DATE OF BIRTH

Jan 27th, 1828
(Month) (Day) (Year)

7 AGE

86 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

England

PARENTS

10 NAME OF FATHER

Felix Foote

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Ann Plummer

13 BIRTHPLACE OF MOTHER

(State or country)

England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Felix Foote Sr.

(Address)

Lonaconing Ind

15

Filed

June 20, 1914 J. B. Bueckner

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 19th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 10, 1914, to June 19, 1914,
that I last saw him alive on May 23rd, 1914

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds. 2 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Henry S. Hodgson, M. D.

June 20th, 1914 (Address) Lonaconing Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Old Covey Cemetery June 21, 1914

20 UNDERTAKER

ADDRESS

M. E. Cuckhorn Lonaconing Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

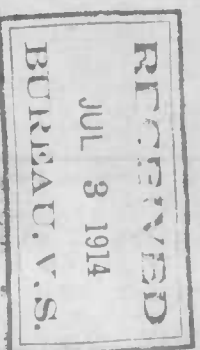
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|--|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>allegany</u> | | 5428 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> (No. <u>182</u>) | | Fayette St.; <u>1st</u> Ward | | Registration Dist. No. <u>1</u> | |
| 2 FULL NAME <u>Ella French</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Married</u> (Write the word) | | | |
| 6 DATE OF BIRTH — — — — —, 1891 (Month) (Day) (Year) | | | | | |
| 7 AGE <u>23</u> yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>Va.</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>"</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. H. Shaw Co</u> (Address) <u>City</u> | | | | | |
| 15 JUL 11 1914 Filed <u>191</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>June 29</u> , 1914 (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from —, 191—, to —, 191—, that I last saw h. — alive on —, 191—, and that death occurred on the date stated above, at <u>89</u> m. The CAUSE OF DEATH* was as follows: <u>Gun Shot Wound</u> <u>Homicidal</u> (Duration) — yrs. — mos. — ds. Contributory Secondary (Duration) — yrs. — mos. — ds. (Signed) <u>Wm. H. Shaw</u> —, M. D. <u>July 1</u> , 1914. (Address) <u>Cumberland, Md.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, if not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Summer Cove</u> DATE OF BURIAL <u>July 2</u> , 1914 | | | | | |
| 20 UNDERTAKER <u>Louis Stem</u> ADDRESS <u>City</u> | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

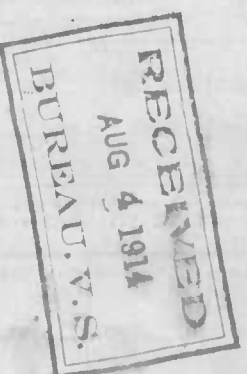
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|--|--|---|--|---------------------------------|--|
| 1 PLACE OF DEATH 5429 | | 129 | | STATE OF MARYLAND | |
| County <u>Allegheny</u> | | | | CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> (No. <u>76</u> Decatur | | St. <u>4</u> Ward) | | Registration Dist. No. <u>4</u> | |
| 2 FULL NAME <u>Myrtle Copeland Gotty</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>May 5</u> , 18 <u>69</u> (Month) (Day) (Year) | | | | | |
| 7 AGE <u>45</u> yrs. <u>1</u> mos. <u>2</u> ds. | | If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at Home</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Penn</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Daniel F Copeland</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Rachael Connelly</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Pa</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John F Gotty</u> (Address) <u>76 Decatur St.</u> | | | | | |
| 15 FILED <u>9 1914</u> <u>1914</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>June 7</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 7</u> , 191 <u>4</u> , to <u>June 7</u> , 191 <u>4</u> , that I last saw h <u>er</u> alive on <u>June 7</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5:40 P.</u> The CAUSE OF DEATH* was as follows: <u>Peritonitis</u> | | | | | |
| Contributory <u>Rupture fibroid tumor</u> Secondary <u>of abdomen</u> (Duration) <u>2</u> yrs. <u>0</u> mos. <u>2</u> ds. (Duration) <u>2</u> yrs. <u>0</u> mos. <u>2</u> ds. (Signed) <u>D. V. Tracey</u> , M. D. <u>June 9</u> , 191 <u>4</u> (Address) <u>Cumberland</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill Cem</u> DATE OF BURIAL <u>June 10</u> , 191 <u>4</u> | | | | | |
| 20 UNDERTAKER <u>Louis Stein</u> ADDRESS <u>City</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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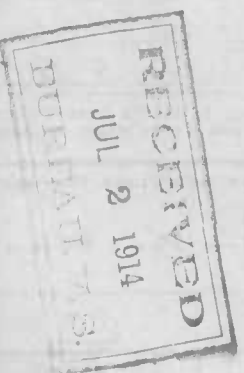
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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| | | | | |
|------------------------------------|--|---|----------------------------------|--|
| 1 PLACE OF DEATH | | 5430 | STATE OF MARYLAND | |
| County <u>Allegheny</u> | | (138) | CERTIFICATE OF DEATH | |
| Village or City <u>Crimmerland</u> | | (No. <u>20</u> <u>Altamont</u> St.; | Registration Dist. No. <u>14</u> | |
| 2 FULL NAME <u>Blauche Gorsuch</u> | | (If death occurred in a hospital or institution, give its NAME instead of street and number.) | | |

| PERSONAL AND STATISTICAL PARTICULARS | | MEDICAL CERTIFICATE OF DEATH | |
|--|---|--|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u> | 16 DATE OF DEATH <u>June 15</u> , 191 <u>4</u> (Month) (Day) (Year) |
| 6 DATE OF BIRTH <u>July 29</u> , 1878 (Month) (Day) (Year) | | 17 I HEREBY CERTIFY, That I attended deceased from <u>June 14</u> , 191 <u>4</u> , to <u>June 15</u> , 191 <u>4</u> , that I last saw her alive on <u>June 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8 P</u> m. | |
| 7 AGE <u>35</u> yrs. <u>11</u> mos. <u>16</u> ds. | | The CAUSE OF DEATH* was as follows: <u>Chest Jacture & pneumonia</u> (Duration) yrs. mos. ds. | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of Industry, business, or establishment in which employed (or employer) <u>Housewife</u> | | Contributory Secondary <u>Pregnancy</u> (Duration) yrs. mos. ds. | |
| 9 BIRTHPLACE (State or country) <u>Ohio</u> | | (Signed) <u>D. M. G. Grains</u> , M. D. <u>June 14</u> , 191 <u>4</u> (Address) <u>Crimmerland, Pa</u> | |
| PARENTS | 10 NAME OF FATHER <u>Samuel Wintersteen</u> | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u> | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | Where was disease contracted, if not at place of death? Former or usual residence..... | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | 19 PLACE OF BURIAL OR REMOVAL <u>Hamilton Ohio</u> | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elisha Gorsuch</u> (Address) <u>20 Altamont Terrace</u> | | DATE OF BURIAL <u>June 17, 1914</u> | |
| 15 Filed <u>11 16 1914</u> <u>Joseph H. Davis</u> REGISTRAR | | 20 UNDERTAKER <u>Louis H. Davis</u> ADDRESS <u>City</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

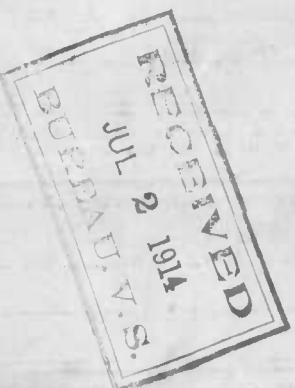
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5431
County Allegheny

Village or City Frostburg (No. 1)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles Hager

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 11 13, 1861
(Month) (Day) (Year)

7 AGE 53 yrs. 1 mos. 27 ds. OR LESS than 1 day, hrs. min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Miner (Coal)
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John Hager
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Elizabeth Wagner
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Hager
(Address) Frostburg Md

15 Filed June 11, 1914 Miss L. Conroy
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1914 to June 9, 1914, that I last saw him alive on June 9, 1914

and that death occurred on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

(Perforation of intestines)
Typhoid Fever
(Duration) — yrs. — mos. 21 ds.

Contributory
Secondary

(Duration) — yrs. — mos. — ds.
(Signed) Dr. W. M. Lane, M. D.
June 9, 1914 (Address) Frostburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS TRANSIENTS, OR RECENT RESIDENTS) Miner Hospital
At place of death — yrs. — mos. 13 ds. to the State — yrs. — mos. — ds.
Where was disease contracted, at Baltimore Md
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Allegheny Cem DATE OF BURIAL 6/11, 1914
20 UNDERTAKER Frostburg Furniture & Undertaking Co. ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

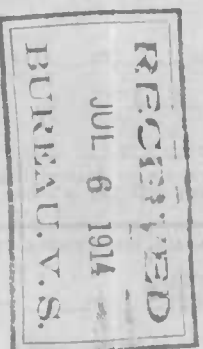
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5432

County AlleghenyVillage or City Lonaconing (No. 10)

St.; Ward

Registration Dist. No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs. Mary K. Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Females 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 31st 1839
(Month) (Day) (Year)

7 AGE 75 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Household duties
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Scotland

PARENTS
10 NAME OF FATHER Kirkwood
11 BIRTHPLACE OF FATHER (State or country) Scotland
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Conrad Lochner(Address) Lonaconing Ind.

15 June 5, 1914 J. T. Bullock
FILED REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to June 3, 1914, that I last saw him alive on June 3, 1914

and that death occurred on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

La grippe
Cerebral hemorrhage

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Henry M. Hodgson, M. D.
June 5th 1914 (Address) Lonaconing Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICINAL, or HOMICINAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Hill Cemetery DATE OF BURIAL June 5, 1914

20 UNDERTAKER M. Eichhorn ADDRESS Lonaconing

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

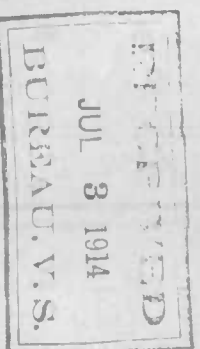
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5433

County

Alleg

Village or City

Frostburg No.

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary E. C. Harding

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

April 10, 1914
(Month) (Day) (Year)

7 AGE

2 yrs. 6 mos. 6 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

John B. Harding
Pa

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

Gertrude Keams

13 BIRTHPLACE OF MOTHER (State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Keams

(Address)

Havallong Inc

15

Filed

June 17, 1914 D. P. Conroy

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1914 to June 16, 1914.

that I last saw her alive on June 15, 1914.

and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantis

(Duration) — yrs. — mos. 3 ds.

Contributory

Secondary

Broke Fed

(Duration) — yrs. — mos. — ds.

(Signed)

J. H. H. H.

, M. D.

June 16, 1914 (Address) Frostburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Allegany Cemeter 6/17, 1914

20 UNDERTAKER

ADDRESS

Frostburg Undertaking & Embalming Co.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

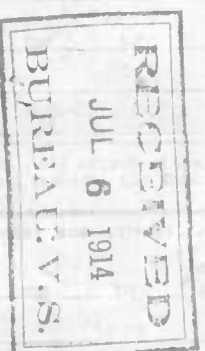
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Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 5434

County Allegheny

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 14

Village or City Cumberland (No. 27 Lancaster St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sevilla Hite

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH Sept 4, 1908 (Month) (Day) (Year)

7 AGE 5 yrs. 9 mos. 1 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Cumberland Md

10 NAME OF FATHER Robert Hite

11 BIRTHPLACE OF FATHER (State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Mary Gray

13 BIRTHPLACE OF MOTHER (State or country) Cumberland Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Robert Hite

(Address) 27 Lancaster St

15 JUN 6 1914 Filed Joseph R. David REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1914, to June 5, 1914, that I last saw her alive on June 5, 1914

and that death occurred on the date stated above, at 1:30 m, The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory Measles Secondary Respiratory

(Duration) 5 yrs. 7 mos. 4 ds.

(Signed) J. R. Owens, M. D.

June 5, 1914. (Address) Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL June 6, 1914

20 UNDERTAKER John Stem ADDRESS Cumbr-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meningitis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5435

Do. Franklin

1 PLACE OF DEATH

County Allegheny

Village or City Uniontown, Pa. (No. 1) Allegheny St. 1 Ward

Registration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ernest Hoover

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 19, 1896
(Month) (Day) (Year)

7 AGE 18 yrs. 23 mos. 1 day, 23 hrs. 5 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Hard Labor
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Garrett Co.

PARENTS

10 NAME OF FATHER Daniel Hoover

11 BIRTHPLACE OF FATHER (State or country) Garrett Co.

12 MAIDEN NAME OF MOTHER Hannett Meier

13 BIRTHPLACE OF MOTHER (State or country) Allegheny Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Hoover
(Address) Uniontown, Pa.

JUN 14 1914
Filed 131

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 12, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1914 to June 12, 1914,
that I last saw him alive on June 12, 1914,
and that death occurred on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Typhoid

(Duration) 7 yrs. 11 mos. 11 ds.

Contributory St. Louis School
Secondary

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) K. D. Franklin, M. D.
June 14, 1914 (Address) Uniontown, Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.
Where was disease contracted, if not at place of death? Uniontown, Pa.
Former or usual residence Uniontown, Pa.

19 PLACE OF BURIAL OR REMOVAL Uniontown, Pa. DATE OF BURIAL 6/15, 1914

20 UNDERTAKER Belcher City ADDRESS Belcher City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1.

C. F. W. R. R.

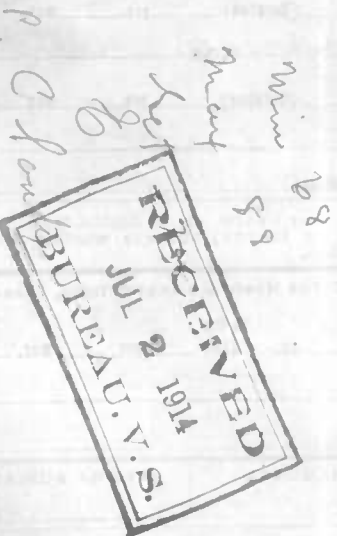
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 6231.

County

Allegheny

Village or City

Frostburg(No. 170)McColloughRegistration Dist. No. 9

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hunter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH

June 10, 1914
(Month) (Day) (Year)

7 AGE

Born dead It LESS than 1 day, _____ hrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Md.

PARENTS

10 NAME OF FATHER

Geo. Hunter

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Anna Roberts

13 BIRTHPLACE OF MOTHER (State or country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15

Filed Oct 17, 1914 Dr. T. L. Connor

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 10, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still - Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. C. [Signature], M. D.
, 191____ (Address) Frostburg, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence. _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 5 1914
BUREAU V.S.

RECEIVED
SEP 5 1914
BUREAU V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5436
 County Allegheny (79)
 Village or City Cumberland (No. 66 Frederick St; Ward)
 Registered No. 4
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs Mary L Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
 (Write the word)

6 DATE OF BIRTH July 1, 1839
 (Month) (Day) (Year)

7 AGE 74 yrs. 11 mos. 17 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

PARENTS
 10 NAME OF FATHER Geo Jackson
 11 BIRTHPLACE OF FATHER (State or country) ohio
 12 MAIDEN NAME OF MOTHER Elizabeth Danson
 13 BIRTHPLACE OF MOTHER (State or country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Johnson

(Address) Cumberland

15 JUN 22 1914 Ralph R. Baird
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1914 to June 20, 1914,
 that I last saw HE/ER alive on June 17, 1914.

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy

Do not know (Duration) yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis

Do not know (Duration) yrs. mos. ds.

(Signed) J. V. V. Denning, M. D.

June 20, 1914 (Address) 115 N. Center St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ross Hill June 22, 1914

20 UNDERTAKER ADDRESS

John C. Wolford Cumberland

If more blanks are needed, address State Registrar, E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | | |
|---|-----------------|--|--|---|--|
| 1 PLACE OF DEATH | | 5437 | | STATE OF MARYLAND | |
| County | | Allegany | | CERTIFICATE OF DEATH | |
| Village or City | | Cumberland | | Registration Dist. No. 4 | |
| No. | | B&O Reserve | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| St. | | 5 | | Ward) | |
| 2 FULL NAME James Edward Jones | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| Male | White | Single | | | |
| 6 DATE OF BIRTH | | | | | |
| Dec 31, 1907 | | | | | |
| (Month) (Day) (Year) | | | | | |
| 7 AGE | | | | | |
| 7 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION | | | | | |
| (a) Trade, profession, or particular kind of work none | | | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) none | | | | | |
| 9 BIRTHPLACE (State or country) Md | | | | | |
| PARENTS | | | | | |
| 10 NAME OF FATHER Edward Jones | | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) Md | | | | | |
| 12 MAIDEN NAME OF MOTHER Martha Brooks | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Md | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) Ed Jones | | | | | |
| (Address) 151914 | | | | | |
| 15 Filed 15 1914 | | | | | |
| 1914 | | | | | |
| REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH June 13, 1914 | | | | | |
| (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from June 13 th , 1914, to June 13 th , 1914 | | | | | |
| that I last saw him alive on June 13 th , 1914 | | | | | |
| and that death occurred on the date stated above, at 4:30 P.M. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | |
| Accidental Drowning | | | | | |
| (Duration) yrs. mos. ds. | | | | | |
| Contributory Secondary Accidental Drowning | | | | | |
| (Duration) yrs. mos. ds. | | | | | |
| (Signed) J. P. Burns, M. D. | | | | | |
| June 15 th , 1914 (Address) 4183 Balt. St. | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death 2 hrs. In the State 7 yrs. 5 mos. 13 ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence 27 Baker St. | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | | |
| Rose Hill Cem June 15, 1914 | | | | | |
| 20 UNDERTAKER | | | | | |
| Jonis Stein | | | | | |
| ADDRESS | | | | | |
| Blt | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

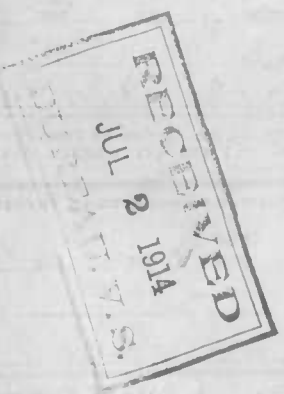
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5438
 County Allegheny 39
 Village or City Cumberland (No. 36, Emily St.; 5 Ward)
 2 FULL NAME Fredrick T. Kaiser
 Registration Dist. No. 4
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married.
 (Write the word)

6 DATE OF BIRTH Sept. -, 1849
 (Month) (Day) (Year)

7 AGE 64 yrs. 9 mos. - ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Barber
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER John Kaiser

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Grayson

(Address) City

15 JUN 25 1914
 Filed Ralph P. Laird
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 22, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to June 20, 1914.

that I last saw him alive on June 20, 1914

and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Epithelioma of lower lip
 (Duration) 2 yrs. mos. ds.

Contributory
 Secondary

(Signed) Edward Harris, M. D.
6/24/1914, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hotel St. Paul DATE OF BURIAL June 25, 1914

20 UNDERTAKER Mrs. L. L. L. L. ADDRESS Cumt

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

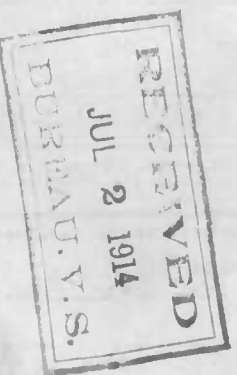
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH 5439 | | STATE OF MARYLAND | |
| County Allegheny | | CERTIFICATE OF DEATH | |
| Village or City Cumberland (No. 42 , Valley) | | Registration Dist. No. 4 | |
| 2 FULL NAME Jannette Knatz | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX Female | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word) | |
| 6 DATE OF BIRTH May 15, 1914 (Month) (Day) (Year) | | | |
| 7 AGE 41 yrs. 1 mos. 0 ds. | | If LESS than 1 day.....hrs. OR.....min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Home | | | |
| 9 BIRTHPLACE (State or country) Md. | | | |
| PARENTS | 10 NAME OF FATHER Archibald Cameron | | |
| | 11 BIRTHPLACE OF FATHER (State or country) Scotland | | |
| | 12 MAIDEN NAME OF MOTHER Jean McClukie | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) Scotland | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Geo F Knatz (Address) 42 Valley St. | | | |
| 15 Filed 17 1914 , 191 Joseph F Knatz REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH June 15, 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from May 23, 1914 , to June 15, 1914 , that I last saw her alive on June 15, 1914 , and that death occurred on the date stated above, at 8 P. m. , The CAUSE OF DEATH* was as follows: Chronic Myocarditis about 4 (Duration) yrs. mos. ds. | | | |
| Contributory Mitral incompetency Secondary second year (Duration) yrs. mos. ds. | | | |
| (Signed) H. V. Denny , M. D. June 16, 1914 . (Address) 115 N. Center St. | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence..... | | | |
| 19 PLACE OF BURIAL OR REMOVAL Home | | DATE OF BURIAL June 18, 1914 | |
| 20 UNDERTAKER Louis Stein | | ADDRESS City | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative helpfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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' PLACE OF DEATH 5440
 County Allegheny
 Village or City Lawrenceville No. 89
 St. _____ Ward _____
 Registration Dist. No. 8
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 FULL NAME Clarence Lambert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)
 6 DATE OF BIRTH July 9th, 1912
 (Month) (Day) (Year)
 7 AGE 1 yr. 11 mos. — ds. If LESS than 1 day, _____ hrs. OR _____ min. ?
 8 OCCUPATION None
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 9 BIRTHPLACE (State or country) Lawrenceville W. Va.
 10 NAME OF FATHER A. C. Lambert
 11 BIRTHPLACE OF FATHER (State or country) W. Va.
 12 MAIDEN NAME OF MOTHER Lydia Callahan
 13 BIRTHPLACE OF MOTHER (State or country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Smith(Address) Lawrenceville

15

Filed June 9, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8th, 1914
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1914, to June 8th, 1914, that I last saw her alive on June 7th, 1914, and that death occurred on the date stated above, at 9 a. m.
 The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) _____ yrs. 1 mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Skilling, M. D.

June 8th, 1914 (Address) Lawrenceville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence Lawrenceville

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Old Cemetery

June 10, 1914

20 UNDERTAKER

ADDRESS

M. E. Eickman

Lawrenceville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

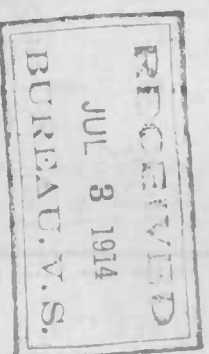
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5441
 County Allegheny (91)
 Village or City Westernport No. St. Ward
 2 FULL NAME Martha Charlotte Latham
 Registration Dist. No. VI
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 12, 1914
 (Month) (Day) (Year)

7 AGE 0 yrs. 1 mos. 16 ds. IT LESS than 1 day, . . . hrs. OR . . . min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Westernport Md

10 NAME OF FATHER R E Latham

11 BIRTHPLACE OF FATHER (State or country) New York City

12 MAIDEN NAME OF MOTHER Sarah Welsh

13 BIRTHPLACE OF MOTHER (State or country) Westernport Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R E Latham

(Address) Westernport Md

15 Filed June 28, 1914
A. M. McLaughlin
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1914 to June 28, 1914, that I last saw her alive on June 28, 1914

and that death occurred on the date stated above, at 9:00 A.M.
 The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. M. McLaughlin M. D.

June 28, 1914 (Address) Westernport Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westernport Md DATE OF BURIAL June 28, 1914

20 UNDERTAKER M. J. Redlock ADDRESS Carlisle Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

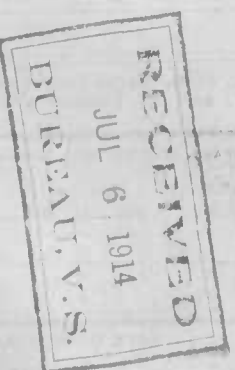
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative seatfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(valuing, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5442

(61)

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty accersanyRegistration Dist. No. 4Village or City Cumberland (No. Wm Hospital) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Herbit Lee Isaac

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED divorced
(Write the word)

6 DATE OF BIRTH June 6, 1882
(Month) (Day) (Year)

7 AGE 27 yrs. 5 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Labor on
(b) General nature of industry, business, or establishment in which employed (or employer) Wm RR Co

9 BIRTHPLACE (State or country) WVa

PARENTS
10 NAME OF FATHER Garret Isaac
11 BIRTHPLACE OF FATHER (State or country) WVa
12 MAIDEN NAME OF MOTHER Ella Isaac
13 BIRTHPLACE OF MOTHER (State or country) WVa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Garret Isaac
(Address) ackerman WVa

15 JUN 10 1914
Filed 191 Joseph L. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 9, 1914, that I last saw him alive on June 8, 1914

and that death occurred on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Meningitis.

(Duration) yrs. mos. 11 ds.

Contributory
Secondary

(Signed) W. R. Hodges M. D.
June 9, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 8 ds. In the State yrs. mos. 8 ds.

Where was disease contracted, ackerman, W. Va.
If not at place of death?

Former or usual residence ackerman, W. Va.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ackerman WVa June 11, 1914

20 UNDERTAKER

ADDRESS

ackerman WVa Cumberland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tranition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5443

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Allegheny

CP

61

Registration Dist. No.

12

Village or City

Ocean

(No. _____)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Walter Royal Logsdon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 STATUS;

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

*July**2**1881*

(Month)

(Day)

(Year)

7 AGE

33

yrs.

11

mos.

13

ds.

IT LESS THAN

1 day, _____ hrs.

OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Miner + Out Sick work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Eckhart

10 NAME OF FATHER

Anthony Logsdon

11 BIRTHPLACE OF FATHER

(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Rachel Folk

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rachel Folk Logsdon

(Address)

New Germany

15

Filed

*June 16, 1914**H. H. Charles*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June**13*

(Month)

(Day)

, 1914 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 8

, 1914

to

June 13

, 1914

that I last saw him alive on

June 10

, 1914

and that death occurred on the date stated above, at

9 P.

m.

The CAUSE OF DEATH* was as follows:

Meningitis(Duration) _____ yrs. _____ mos. *6* ds.

Contributory (Secondary)

old injury(Duration) *2* yrs. _____ mos. _____ ds.

(Signed)

J. H. Ravencroft

, M. D.

June 16, 1914

(Address)

Midland, Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

_____ yrs. _____ mos. _____ ds.

In the

State

_____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Mt Savage**June 18, 1914*

20 UNDERTAKER

ADDRESS

*Eichorn**Louise*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

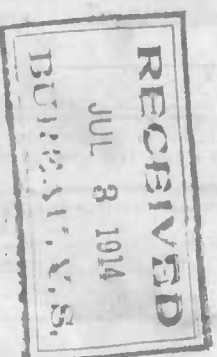
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1 PLACE OF DEATH 5444

County AlleganyVillage or City Westonport (No. 5)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. VI

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Art Samuel. 6th month Lyons

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---------------------------------|--|
| 3 SEX <u>male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u> |
| 6 DATE OF BIRTH <u>June 10th</u> , 191 <u>4</u> (Month) (Day) (Year) | | |
| 7 AGE <u>6th month</u> <u>still birth</u> <u>before</u> yrs. mos. ds. It LESS than 1 day, hrs. OR min.? | | |

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Westernport Md.

| | |
|---------|--|
| PARENTS | 10 NAME OF FATHER <u>John Lyons</u> |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Westernport</u> |
| | 12 MAIDEN NAME OF MOTHER <u>Anna Sharts</u> |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Westernport</u> |

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lyons(Address) Westernport15 Filed July 10, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10th Probably, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from June 10th 1914, to June 13th 1914.
that I last saw him still born alive on June 13th, 1914.and that death occurred on the date stated above, at 11 m.
The CAUSE OF DEATH* was as follows:Promotion birth. Separation of placenta &c Hemorrhage & labor followed. (Duration) still b. Birth. ds.

Contributory (Secondary)

(Signed) J. S. F. Abbott, M. D.
June 11th, 1914 (Address) Piedmont

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Westernport Md. DATE OF BURIAL 6/10, 191420 UNDERTAKER Father ADDRESS Westernport Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

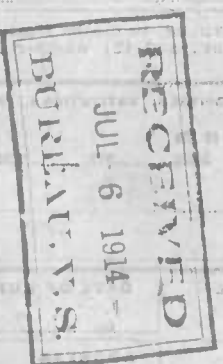
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1 PLACE OF DEATH 5445

County AlleghenyVillage or City Cresaptown (No. 78)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 5

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Herbert Wm Macalee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov. 3, 1890
(Month) (Day) (Year)

7 AGE 23 yrs. 7 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS
10 NAME OF FATHER Sam'l K. Moore
11 BIRTHPLACE OF FATHER (State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (State or country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. A. Pennington
(Address) Cresaptown, "Pena St."

15 Filed June 8, 1914 Leo M. Cavanaugh M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1914, to June 7, 1914.

that I last saw him alive on June 6, 1914

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 2 yrs. mos. ds.

Contributory Tuberculosis of Pancreas
Secondary

(Duration) yrs. mos. ds.

(Signed) Leo M. Cavanaugh, M. D.
July 8, 1914 (Address) Cresaptown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cresaptown DATE OF BURIAL June 8, 1914

20 UNDERTAKER Louis Stein ADDRESS Cresaptown, Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

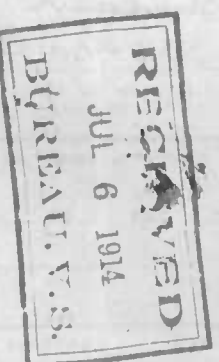
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5446

County KelleganyVillage or City Franklin (No. 1)

St.; Ward)

Registration Dist. No. VI

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Delan McTigue

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH June 17, 1887
(Month) (Day) (Year)

7 AGE 27 yrs. 7 mos. 3 ds. IF LESS than 1 day,.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Prof. Miner
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9 BIRTHPLACE (State or country) Oh

PARENTS
10 NAME OF FATHER Stelery McTigue
11 BIRTHPLACE OF FATHER (State or country) Oh
12 MAIDEN NAME OF MOTHER Catherine McTigue
13 BIRTHPLACE OF MOTHER (State or country) Oh

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stelery McTigue(Address) Wheatport, Md.

15 Filled June 20, 1914 M. J. McLaughlin
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 11, 1914, to June 20, 1914, that I last saw him alive on June 20, 1914

and that death occurred on the date stated above, at 1200 P. M.
The CAUSE OF DEATH* was as follows:

St. of Pharyngeal Cancer

Contributory (Duration) yrs. mos. ds. 14
Secondary Carcinoma of throat

(Signed) M. J. McLaughlin, M. D.
June 20, 1914 (Address) Wheatport, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Wheatport, Md. DATE OF BURIAL June 22, 1914

20 UNDERTAKER Wm. J. Preflock ADDRESS Crisfield, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

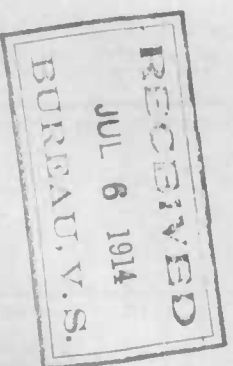
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | | | |
|---|--|---------------------------------|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>Allegany</u> | | 5447 | | 69 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Near Cumberland</u> | | (No. <u>Sylvan Retreat</u> | | St. <u>Ward</u> | | Registration Dist. No. <u>14</u> | |
| 2 FULL NAME <u>IDA M. MC MILLAN</u> | | | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Female</u> | | 4 COLOR OR RACE <u>White</u> | | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> | | | |
| 6 DATE OF BIRTH <u>1</u> 1882 (Month) (Day) (Year) | | | | | | | |
| 7 AGE <u>32</u> yrs. <u>—</u> mos. <u>—</u> ds. OR <u>—</u> mn. ? If LESS than 1 day, <u>—</u> hrs. | | | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>George B. McMillan</u> | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Elizabeth Meyers</u> | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Minnie Eelhorn</u> (Address) <u>Lanesburg Ind.</u> | | | | | | | |
| 15 <u>JUN 10 1914</u> Filed <u>1914</u> <u>Ralph R. David</u> REGISTRAR | | | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | | | |
| 16 DATE OF DEATH <u>6</u> - <u>10</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 1</u> , 191 <u>4</u> , to <u>June 8</u> , 191 <u>4</u> , that I last saw h. <u>sr.</u> alive on <u>June 8</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5:30 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Epilepsy</u> (Duration) <u>8</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory Secondary (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>W. H. White</u> , M. D. <u>6/10</u> , 191 <u>4</u> (Address) <u>Cumberland Ind.</u> | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>8</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>8</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, <u>Garrett Co. Ind.</u> If not at place of death? Former or usual residence <u>Garrett Co. Ind.</u> | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Moscow Ind.</u> | | | | DATE OF BURIAL <u>June 10</u> , 191 <u>4</u> | | | |
| 20 UNDERTAKER <u>Louis Stone</u> | | | | ADDRESS <u>City</u> | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1. | | | | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

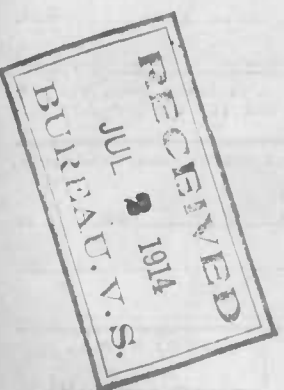
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Idianthion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|--|---|--|---|--|
| 1 PLACE OF DEATH County <u>Allegany</u> | | 5448 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Barton</u> (No. _____, St.; _____ Ward) | | Registration Dist. No. <u>7</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Magnuder</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>white</u> | 5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Single</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>June 22, 1914</u> (Month) (Day) (Year) | | | | | |
| 7 AGE _____ yrs. _____ mos. <u>2</u> ds. OR LESS than 1 day, _____ hrs. _____ min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Allegany Co. Md.</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Frank Magnuder</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Gaith C Md</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Estella Shubant</u> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Alleg. Co Md</u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank Magnuder</u> (Address) <u>Barton Md</u> | | | | | |
| 15 Filed <u>June 24, 1914</u> <u>S. A. Boucher</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>June 24, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on <u>June 23</u> , 191 <u>4</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Not definitely determined</u> <u>He then seemed to have</u> <u>been some bronchial obstruction</u> <u>Atelectasis</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary <u>CW</u> (Signed) <u>S. A. Boucher</u> , M. D. <u>June 24, 1914</u> (Address) <u>Barton, Ind</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Alleg. Co Laurel Hill Cem.</u> | | | | DATE OF BURIAL <u>June 24, 1914</u> | |
| 20 UNDERTAKER <u>D. S. Boal</u> | | | | ADDRESS <u>Barton</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

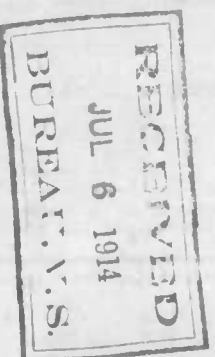
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1 PLACE OF DEATH

5449

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Allegany

Registration Dist. No.

4

Village or City

Emberland

(No.)

18

Attamont Terrace

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bessie T. Mahaney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Aug 17, 1878

(Month)

(Day)

(Year)

7 AGE

35

yrs.

10

mos.

7

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Music teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

Private

9 BIRTHPLACE

(State or country)

md

PARENTS

10 NAME OF FATHER

J. H. B. Mahaney

11 BIRTHPLACE OF FATHER

(State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Emily J. Metz.

13 BIRTHPLACE OF MOTHER

(State or country)

md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Emily Mahaney

(Address)

18 Attamont Terrace

15

Filed JUN 26 1914, 1914

Pauph R. Baird

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 24, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb 20, 1914, to

June 24, 1914

that I last saw him alive on

June 23, 1914

and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhoea

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. J. Trace

M. D.

June 26, 1914 (Address)

Bessie T. Mahaney, md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill C. & S.

6/26, 1914

20 UNDERTAKER

ADDRESS

Louis's Store City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevegt further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. L. Faganbaker

5450

1 PLACE OF DEATH

County

Allegheny

Village or City

Westport

(No.

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Florence Leary Michaels

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Feb 2, 1898

7 AGE

16 yrs. 4 mos. 0 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

West Va.

PARENTS

10 NAME OF FATHER

H. R. Michaels

11 BIRTHPLACE OF FATHER (State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Mary Faganbaker

13 BIRTHPLACE OF MOTHER (State or country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. R. Michaels

(Address)

Westport road

15

Filed

June 7, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 7, 1914

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid - followed by bacterial meningitis.

Contributory (Duration) yrs. mos. ds. Duration about 21 days.

(Signed) L. Faganbaker, M. D. June 9, 1914 (Address) Westport, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Phibos. Westport road

June 10, 1914

20 UNDERTAKER

ADDRESS

W. H. Endlock

Liedman

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

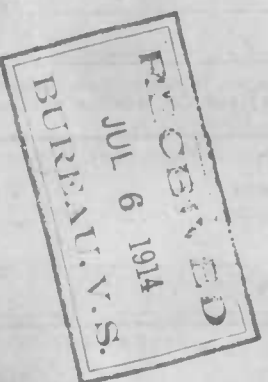
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*; *Carcin-*

oma. Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | |
|---|--|--|--|---|--|
| 1 PLACE OF DEATH County <u>allergany</u> | | 5451 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> (No. <u>3</u> <u>Water</u> St.; Ward) | | Registration Dist. No. <u>4</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>Dr. J. A. Middleton</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | | | |
| 6 DATE OF BIRTH <u>Mar 29</u> , 1914 (Month) (Day) (Year) | | | | | |
| 7 AGE yrs. <u>2</u> mos. <u>7</u> ds. | | If LESS than 1 day, hrs. <u>?</u> OR min. <u>?</u> | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>at Home</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) <u>md</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>H. K. Middleton</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>md</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Lula Wilson</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>md</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. D. Ross</u> (Address) <u>city</u> | | | | | |
| 15 <u>June 23 1914</u> , 191 <u>4</u> <u>Ralph R. Bird</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>June 22</u> , 191 <u>4</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 1</u> , 191 <u>4</u> , to <u>June 22</u> , 191 <u>4</u> , that I last saw her alive on <u>June 22</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Gastro-enteritis</u> (Duration) yrs. <u>33</u> mos. <u>33</u> ds. | | | | | |
| Contributory Secondary (Duration) yrs. <u>33</u> mos. <u>33</u> ds. | | | | | |
| (Signed) <u>R. H. Trevaskis</u> , M. D. <u>June 22, 1914</u> (Address) <u>27 Green St.</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>?</u> mos. <u>?</u> ds. In the State yrs. <u>?</u> mos. <u>?</u> ds. Where was disease contracted, If not at place of death? Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Triggstown</u> | | | | DATE OF BURIAL <u>June 23, 1914</u> | |
| 20 UNDERTAKER <u>J. E. Wolford</u> | | | | ADDRESS <u>Cumberland</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto. Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

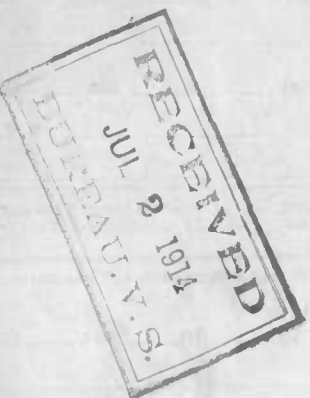
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5452

County

Allegheny

Village or City

Lima

(No.)

St.;

Ward)

Registration Dist. No. 8

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Donald Buller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Dec

12th

1866

(Month)

(Day)

(Year)

7 AGE

47 yrs

5 mos

20 ds.

It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Coal Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

Mining Coal

9 BIRTHPLACE

(State or country)

Sharon, Penn.

PARENTS

10 NAME OF FATHER

Thomas Buller

11 BIRTHPLACE OF FATHER

(State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Jessie Archibald

13 BIRTHPLACE OF MOTHER

(State or country)

Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Donald

(Address)

Lima, Pa.

15

Filed

June 2, 1914

J. O. Buller

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

1st

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 11th

1914

to

June 1st

1914

that I last saw him alive on

June 1st

1914

and that death occurred on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Injured in coal mine.
Injury caused by falling rock.

(Duration)

yrs.

mos

21 ds.

Contributory

Secondary

Previous mine injury

(Duration)

yrs.

mos

ds.

(Signed)

Henry W. Hodgson

M. D.

June 2nd

1914

(Address)

Lima, Pa.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lima, Pa.

June 3, 1914

20 UNDERTAKER

ADDRESS

R. Spier

Lima, Pa.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECORDED
JUL 8 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5453

County AlleghenyVillage or City Cumberland (No. W. Md. Hosp. St.; 6 Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Grant Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct 25, 1886
(Month) (Day) (Year)

7 AGE 27 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) B. O. R. R.

9 BIRTHPLACE (State or country) Pa.10 NAME OF FATHER A. P. Miller11 BIRTHPLACE OF FATHER (State or country) Pa.12 MAIDEN NAME OF MOTHER Sarah Burkey13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Miller(Address) S. B. Miller15 JUN 2 1914 Joseph H. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1914, to June 2, 1914.
that I last saw him alive on June 1, 1914

and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Camp hook bone of
chest - thrown under
engine in R. R. wreck
(Duration) yrs. mos. ds.

Contributory Duration of Injury

(Signed) E. B. Claybrook M. D.
June 2, 1914 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State Pa. yrs. mos. ds.
Where was disease contracted, Cook, Miss, Pa.
If not at place of death?
Former or usual residence 105-5th St. City

19 PLACE OF BURIAL OR REMOVAL Johnstown Pa. DATE OF BURIAL 8/3, 191420 UNDERTAKER Louis Stein ADDRESS City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

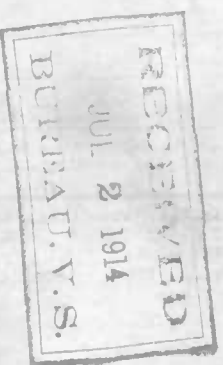
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5454

County AlleghenySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4Village or City Cumberland (No. Front and Baltimore St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Mar 23, 1884
(Month) (Day) (Year)

7 AGE 80 yrs. 3 mos. 3 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Hotel Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER George Miller
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER don't know
13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Miller(Address) Hyndman

15

JUN 29 1914

Joseph R. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1914, to June 27, 1914.
that I last saw him alive on June 26, 1914

and that death occurred on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(7. nitral regurgitation)
(Duration) 7 yrs. 9 mos. 9 ds.

Contributory
Secondary

(Duration) 7 yrs. 9 mos. 9 ds.
(Signed) James Johnson, M. D.
June 27, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Hyndman DATE OF BURIAL June 29, 1914

20 UNDERTAKER

General Ford ADDRESS Cumberland

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

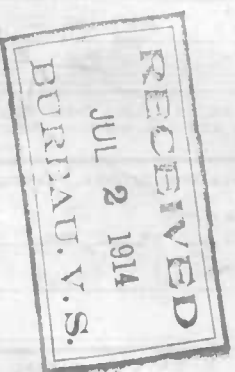
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | | |
|---|--|--|--|---------------------------------|--|
| 1 PLACE OF DEATH | | 5455 | | STATE OF MARYLAND | |
| County <u>Allegany</u> | | (66) | | CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> | | (No. <u> </u>) | | Registration Dist. No. <u>4</u> | |
| | | <u>Paca</u> | | St.; <u> </u> Ward) | |
| 2 FULL NAME | | <u>Mary M. Mullin</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | | | |
| <u>female</u> | <u>white</u> | <u>Widow</u> | | | |
| 6 DATE OF BIRTH | | | | | |
| <u>Aug. 27</u> , 1 <u>849</u> | | | | | |
| (Month) (Day) (Year) | | | | | |
| 7 AGE | | | | | |
| <u>64</u> yrs. <u>9</u> mos. <u>22</u> ds. OR <u> </u> min. ? | | | | | |
| 8 OCCUPATION | | | | | |
| (a) Trade, profession, or particular kind of work <u>None</u> | | | | | |
| (b) General nature of Industry, business, or establishment in which employed (or employer) | | | | | |
| 9 BIRTHPLACE (State or country) | | | | | |
| <u>Canton, Ohio</u> | | | | | |
| PARENTS | 10 NAME OF FATHER | | | | |
| | <u>Ruppert</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) | | | | |
| | <u>Unknown</u> | | | | |
| 12 MAIDEN NAME OF MOTHER | | | | | |
| <u> </u> | | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | | | | | |
| <u> </u> | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | | | |
| (Informant) <u>Mrs Alfred Reid</u> | | | | | |
| (Address) <u>Paca Street</u> | | | | | |
| 15 | | | | | |
| Filed <u>JUN 22 1914</u> <u>Ralph R. Baird</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH | | | | | |
| <u>June 19</u> , 191 <u>4</u> | | | | | |
| (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from | | | | | |
| <u>June 14</u> , 191 <u>4</u> , to <u>June 19</u> , 191 <u>4</u> . | | | | | |
| that I last saw h <u> </u> alive on <u>June 19</u> , 191 <u>4</u> . | | | | | |
| and that death occurred on the date stated above, at <u>11:45</u> a.m. | | | | | |
| The CAUSE OF DEATH* was as follows: | | | | | |
| <u>Paralysis</u> | | | | | |
| (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| Contributory <u>Bright Disease</u> | | | | | |
| Secondary | | | | | |
| (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| (Signed) <u>Shirley H. Thompson</u> , M. D. | | | | | |
| <u>June 22</u> , 191 <u>4</u> (Address) <u>Quintessence Rd</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | | | |
| At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. | | | | | |
| Where was disease contracted, If not at place of death? | | | | | |
| Former or usual residence | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | | | | |
| <u>Rose Hill Cem</u> | | | | | |
| DATE OF BURIAL | | | | | |
| <u>June 22</u> , 191 <u>4</u> | | | | | |
| 20 UNDERTAKER | | | | | |
| <u>Louis Stein</u> | | | | | |
| ADDRESS | | | | | |
| <u>City</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc. When a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5456

County

Ally

Village or City

Bald Summit

(No.)

St.;

Ward)

Registration Dist. No.

11

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant Neet

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

M-

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORED
(Write the word)

ched

6 DATE OF BIRTH

6-14

(Month)

(Day)

1914

(Year)

7 AGE

0 yrs. 0 mos. 0 ds.

If LESS than
1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF FATHER

John Neet

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Loretta Higgins

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Loretta Neet

(Address)

Bald Summit Md

15

Filed....., 191.....

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6-14

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

6/14

1914, to

6-14

1914,

that I last saw him alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration)..... yrs. mos. ds.

Contributory
SecondaryMother's ill causing
pernicious labor

(Duration)..... yrs. mos. ds.

(Signed)

G. A. Wilson

, M. D.

6/15, 1914 (Address) Baltimore Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death..... yrs. mos. ds.

In the

State..... yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore - Md

6/15, 1914

20 UNDERTAKER

ADDRESS

John Neet - Father

Bald Summit Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

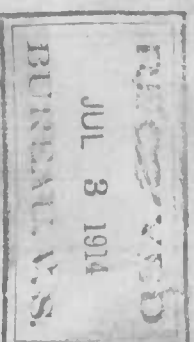
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH County <u>Allegheny</u> <u>5457</u> | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> (No. <u>106</u> , <u>Third</u> St.; Ward) | | Registration Dist. No. <u>17</u> | |
| 2 FULL NAME <u>Infant Negolini</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Italian</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | |
| 6 DATE OF BIRTH <u>June 27</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>1</u> yrs. <u>—</u> mos. <u>—</u> ds. | | It LESS than 1 day, <u>—</u> hrs. <u>—</u> min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> | | | |
| 9 BIRTHPLACE (State or country) <u>MD</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Biagio Negolini</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Italy</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>Ottavia Orterzi</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>Italy</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Don Difazio</u> (Address) <u>Springdale St.</u> | | | |
| 15 Filed <u>Jun 30 1914</u> | | 16 REGISTRAR <u>Joseph R. Davis</u> | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 27</u> , 191 <u>4</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 27</u> , 191 <u>4</u> , to <u>June 27</u> , 191 <u>4</u> , that I last saw him alive on <u>June 27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Premature birth</u> <u>(Still-Birth)</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. | | | |
| Contributory Secondary (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. | | | |
| (Signed) <u>J. H. Spicer</u> , M. D. <u>June 29</u> , 191 <u>4</u> . (Address) <u>Cumberland Md.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>—</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. P & P. Church</u> | | DATE OF BURIAL <u>June 28</u> , 191 <u>4</u> | |
| 20 UNDERTAKER <u>Louis Starn</u> | | ADDRESS <u>Catonsville</u> | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Tropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5458

County

Allegheny

Village or City

Cumberland (Not Western Md. Hosp. St. Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Geeli Nicola

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

Unknown, 1 (Month) (Day) (Year)

7 AGE

Aged about 18 yrs. mos. ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Italy

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Butler

(Address)

City

15

Filed

JUN 17 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 15, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1914 to June 16, 1914.

that I last saw him alive on June 16, 1914.

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. ds.

Contributory

Typhoid fever

Secondary

(Duration) yrs. mos. ds.

(Signed)

W. G. Grawie, M. D.

June 17, 1914 (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Patrick's Jun 18, 1914

20 UNDERTAKER

ADDRESS

St. Patrick's City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

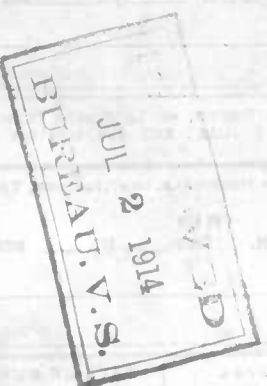
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5459

County AlleghenyVillage or City Union (No. Allegheny Hosp St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Norton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH July 22, 1846
(Month) (Day) (Year)

7 AGE 67 yrs 11 mos 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work retiree
(b) General nature of industry, business, or establishment in which employed (or employer) House Keeper

9 BIRTHPLACE (State or country) Ind.

PARENTS
10 NAME OF FATHER Do not know
11 BIRTHPLACE OF FATHER (State or country) " " "
12 MAIDEN NAME OF MOTHER " " "
13 BIRTHPLACE OF MOTHER (State or country) " " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Norton(Address) Lawrence St. W. Va.

15 JUN 27 1914
Filed 1914 Joseph H. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1914, to June 26, 1914.

that I last saw her alive on June 26, 1914.

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia & shock, following operation

(Duration) yrs. mos. 1/2 ds.

Contributory Strangulated Hernia
Secondary

(Duration) yrs. mos. 2 ds.

(Signed) Thos. H. Broad, M. D.

June 26, 1914 (Address) Reebersburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place Allegheny Hosp In the of death yrs. mos. ds. State yrs. mos. 1/2 ds.

Where was disease contracted, Parr Pass W. Va
If not at place of death?

Former or usual residence Parr Pass, W. Va

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parr Pass W. Va 6/27, 1914

20 UNDERTAKER ADDRESS

Louis Stene City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

B. O. R. R.

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[Approved by U. S. Census and American Public Health
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| | | | | | |
|---|---|---|--|---|--|
| 1 PLACE OF DEATH County <u>Allegheny</u> | | 5460 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Cumberland</u> (No. <u>West Main Hwy</u>) | | St.; Ward | | Registration Dist. No. <u>4</u> | |
| 2 FULL NAME <u>Peter Kinn</u> | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWER, OR DIVORCED (Write by word) <u>Married</u> | | | |
| 6 DATE OF BIRTH <u>Dec 1, 1884</u> (Month) (Day) (Year) | | 7 AGE <u>74</u> yrs. <u>6</u> mos. <u>27</u> ds. OR LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Labourer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>City</u> | | | | | |
| 9 BIRTHPLACE (State or country) <u>Ind</u> | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>"</u> | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Kinn</u> (Address) <u>6 Arch St</u> | | | | | |
| 15 <u>JUN 29 1914</u> 191 <u>4</u> <u>Joseph R. Dyer</u> REGISTRAR | | | | | |
| MEDICAL CERTIFICATE OF DEATH | | | | | |
| 16 DATE OF DEATH <u>June 28, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 21, 1914</u> , to <u>June 28, 1914</u> , that I last saw him alive on <u>June 28, 1914</u> , and that death occurred on the date stated above, at <u>9 P. m.</u> , The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> (Duration) yrs. mos. <u>8</u> ds. Contributory <u>arteriosclerosis</u> Secondary (Duration) <u>5</u> yrs. mos. ds. (Signed) <u>C. L. Higgins</u> , M. D. <u>June 29, 1914</u> (Address) <u>Cumberland Md</u> | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>9</u> ds. In the State yrs. mos. ds. Where was disease contracted, <u>43 Springdale</u> If not at place of death? <u>43</u> Former or usual residence <u>43</u> | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill Cem</u> DATE OF BURIAL <u>July 1, 1914</u> | | | | | |
| 20 UNDERTAKER <u>Louis Steen</u> ADDRESS <u>City</u> | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

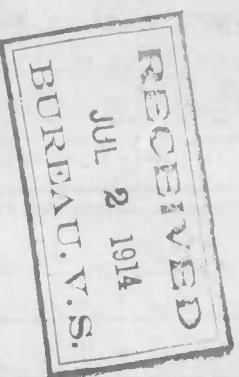
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5461

County AllyVillage or City Eckhart

(No. _____)

St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Paten

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH 9 - 17, 1858
(Month) (Day) (Year)

7 AGE 55 yrs. 8 mos. 22 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Chabot(Address) Lothburg Md

15 Filed _____, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 11

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 - 9, 1914
(Month) (Day) (Year)

17 6/7 I HEREBY CERTIFY, That I attended deceased from 1914, to 6/9, 1914,
that I last saw him alive on 6/9, 1914.

and that death occurred on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 5 yrs. _____ mos. _____ ds.
Contributory Heart Disease
Secondary _____

(Signed) G H Nelson, M. D.
6/10, 1914 (Address) Eckhart Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Lothburg DATE OF BURIAL 6/12, 1914

20 UNDERTAKER J. H. Haper ADDRESS Lothburg Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

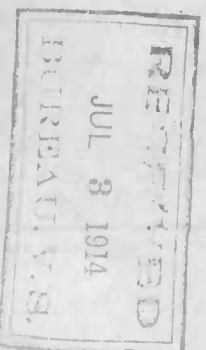
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5462
 County Allegany
 Village or City Westonport (No. 9) St.; Ward VI
 2 FULL NAME Charles Renford

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, Single
~~MARRIED~~
~~WIDOWED~~
~~OR DIVORCED~~
 (Write the word)

6 DATE OF BIRTH Sept 2, 1901
 (Month) (Day) (Year)

7 AGE 13 yrs. 9 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Student
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

PARENTS
 10 NAME OF FATHER Anthony J. Renford
 11 BIRTHPLACE OF FATHER (State or country) Russia
 12 MAIDEN NAME OF MOTHER Katie Gentry
 13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs Katie Renford
 (Address) Westonport Md

15 Filed June 29, 1914 H. M. Wallaugh
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 8, 1914, to June 27, 1914, that I last saw him alive on June 27, 1914, and that death occurred on the date stated above, at 11:30 A.M.
 The CAUSE OF DEATH* was as follows:

Myocardial Infarction
 (Duration) yrs. mos. 10 ds.

Contributory (Secondary) Systemic
 (Duration) yrs. mos. 10 ds.

(Signed) H. M. Wallaugh M. D.
June 29, 1914 (Address) Westonport Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chicks. Westonport June 30, 1914
 20 UNDERTAKER ADDRESS
W. H. Redlock Richmond W. Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

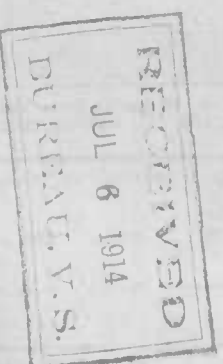
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5463

County

Allegheny

Village or City

E. Elerslie

(No.)

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Susan Powell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Feb 28, 1834
(Month) (Day) (Year)

7 AGE

*80 yrs. 3 mos. 12 ds.*It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Penn.

10 NAME OF FATHER

G. H. Powell

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Anna C. Hoyer

13 BIRTHPLACE OF MOTHER (State or country)

Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. J. J. Powell

(Address)

E. Elerslie Md.

15

Filed..... 191.....

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 9, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY That I attended deceased from

*May 3, 1914, to May 9th, 1914.*that I last saw her alive on *May 9th, 1914.*and that death occurred on the date stated above, at *8:55 P.M.*

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(Duration) yrs. mos. ds.

Contributory (Secondary)

Old age

(Duration) yrs. mos. ds.

(Signed)

J. Kent Smith

M. D.

191..... (Address) *Elerslie's road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Hyndman Pa**June 11, 1914*

20 UNDERTAKER

ADDRESS

*John Sides**Hyndman Pa*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5464

County

Allegany

Village or City

Cumberland, W. M. Hospital

(No.)

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Stillborn Ravenscroft

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June 22, 1914

(Month)

(Day)

(Year)

7 AGE

— yrs. — mos. — ds.

It LESS than
1 day — hrs.
or — min.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Don't Know

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Don't Know

12 MAIDEN NAME OF MOTHER

Mary Ravenscroft

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Ravenscroft

(Address)

Cumberland, Md.

15

JUN 23 1914

Filed

191

Reph R Baird

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

22

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1914, to June 22, 1914.

that I last saw him alive on June 22, 1914.

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

(Still born)

Syphilis

9 mos. intrauterine

(Duration) yrs. mos. ds.

Contributory

Secondary

(Signed) W. R. Hodges - R.B., M. D.

June 22, 1914. (Address) Cumberland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, 16 Flat St. Cumberland, Md.

Former or usual residence Cumberland, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Alleg Co Cem June 23, 1914

20 UNDERTAKER

ADDRESS

Louis Stewer City

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal equiditions, such as "As-thema," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5465

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Allegany

Registration Dist. No.

13

Village or City

Cumberland

(No. 417)

Home

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant - Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Infant

6 DATE OF BIRTH

June 22, 1914
(Month) (Day) (Year)

7 AGE

X yrs. X mos. 1 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Raymond Reynolds

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Thelma Davidson

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thelma Davidson

(Address)

Cumberland Md

15

Filed June 24, 1914 Geo. L. Broadbent

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 23, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 22, 1914, to June 23, 1914, that I last saw him alive on June 23, 1914

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth
(7 1/2 months)
(Duration) yrs. mos. 1 ds.Contributory
Secondary(Duration) yrs. mos. ds.
(Signed) William P. Grant, M. D.
June 23, 1914 (Address) Cumberland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Cem

6/25, 1914

20 UNDERTAKER

ADDRESS

Louis Stein

Cuby

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

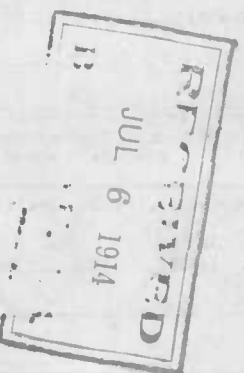
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ- mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio- lent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla- ture of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5466

County Alleghenynear UnionVillage or City Union(No. 1)T. B. SanitoriumRegistration Dist. No. 11St. 11 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sophoria Searfus

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Feb. 15

(Day)

1856

(Year)

7 AGE

58

yrs.

4

mos.

—

ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9 BIRTHPLACE

(State or country)

Pa

PARENTS

10 NAME OF FATHER

Don't Know

11 BIRTHPLACE OF FATHER (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (State or country)

" " "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. F. Searfus.

(Address)

Union, Pa.

15

Filed

JUN 2 1914Joseph P. Davis

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 1st

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

Feb 151914

to

June 1st1914that I last saw her alive on June 1st, 1914and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs(Duration) yrs. 3 mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. L. Owens, M. D.June 2, 1914

(Address)

Cumberland Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS; INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

21

ds.

In the

State

3

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?Cumberland Md

Former or

usual residence

437 Seymour St

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Uniontown Pa6/2, 1914

20 UNDERTAKER

ADDRESS

Louis Reed City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

B.F.G. R.R.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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| 1 PLACE OF DEATH | | 5467 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
|--|--|---|---|---|--|
| County <u>Allegheny</u> | | Village or City <u>Lancaster</u> (No. _____) | | St.; _____ Ward _____ | |
| 2 FULL NAME <u>Mrs. Rosanne Shockey</u> | | Registration Dist. No. <u>8</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | MEDICAL CERTIFICATE OF DEATH | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u> | 16 DATE OF DEATH <u>June 10th</u> , 191 <u>4</u> (Month) (Day) (Year) | | |
| 6 DATE OF BIRTH <u>March 12</u> , 18 <u>36</u> (Month) (Day) (Year) | | | 17 I HEREBY CERTIFY, That I attended deceased from <u>June 19th</u> , 191 <u>3</u> , to <u>June 10th</u> , 191 <u>4</u> , that I last saw her alive on <u>June 10th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4:30 P. m.</u> , The CAUSE OF DEATH* was as follows: <u>Chronic Myocarditis</u> (Duration) <u>One</u> yrs. _____ mos. _____ ds. | | |
| 7 AGE <u>78</u> yrs. <u>2</u> mos. <u>28</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ? | | | Contributory (Secondary) _____ | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ | | | (Duration) _____ yrs. _____ mos. _____ ds. | | |
| 9 BIRTHPLACE (State or country) <u>Pennsylvania</u> | | | (Address) <u>W. B. Skilling</u> , M. D. <u>June 11th</u> , 191 <u>4</u> (Address) <u>Lancaster</u> | | |
| PARENTS | 10 NAME OF FATHER _____ | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u> | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | Where was disease contracted, if not at place of death? _____ Former or usual residence _____ | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u> | | | 19 PLACE OF BURIAL OR REMOVAL <u>Cape Hill, Lancaster</u> DATE OF BURIAL <u>June 12, 1914</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>William B. Shockey</u> (Address) <u>Lancaster, Md.</u> | | | 20 UNDERTAKEN <u>M. Eichhorn</u> ADDRESS <u>Lancaster</u> | | |
| 15 Filed <u>June 11, 1914</u> <u>J. B. Bullock</u> REGISTRAR | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

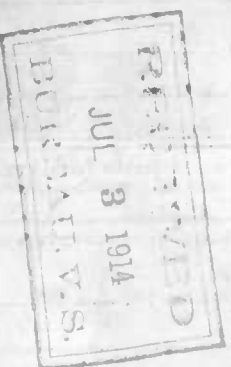
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5468

County

Allegany

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

3

Village or City

Carmichael

(No. 1320)

Va an

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Stillborn)

Sirbaugh

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

June 23, 1914

7 AGE

still born

It LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Allegany Co Md

PARENTS

10 NAME OF FATHER

Jno E Sirbaugh

11 BIRTHPLACE OF FATHER (State or country)

Va

12 MAIDEN NAME OF MOTHER

Clara Shront

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno E Sirbaugh

(Address)

Carmichael Md

15

Filed

June 24, 1914 Geo. L. Broadbent

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 23, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 23, 1914 to June 23, 1914

that I last saw him alive on _____, 1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

still born child

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. E. Sirbaugh, M. D.

June 24, 1914 (Address) Carmichael Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Hill Cem.

6/25, 1914

20 UNDERTAKER

ADDRESS

Louis Stein

City:

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 6 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH County <u>Allegany</u> 5469 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <u>Westonport</u> (No. <u>9</u>) | | Registration Dist. No. <u>6</u> | |
| 2 FULL NAME <u>Theodore R. Taylor</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) | |
| 6 DATE OF BIRTH <u>October 10, 1900</u> (Month) (Day) (Year) | | | |
| 7 AGE <u>13</u> yrs. <u>8</u> mos. <u>7</u> ds. | | If LESS than 1 day, hrs. OR min. ? | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>School</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| 9 BIRTHPLACE (State or country) <u>Maryland</u> | | | |
| PARENTS | | | |
| 10 NAME OF FATHER <u>Henry R. Taylor</u> | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>England</u> | | | |
| 12 MAIDEN NAME OF MOTHER <u>Rebecca Brown</u> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>D. J. Long</u> (Address) <u>Piedmont, W. Va.</u> | | | |
| 15 Filed <u>June 14, 1914</u> <u>1000 William</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>6-13, 1914</u> (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 1st</u> , 1914, to <u>June 13</u> , 1914, that I last saw him alive on <u>June 12</u> , 1914, and that death occurred on the date stated above, at <u>9-4</u> a.m., The CAUSE OF DEATH* was as follows: <u>Typhoid Fever</u> | | | |
| Contributory (Secondary) <u>Meningitis</u> (Duration) <u>1</u> yrs. <u>12</u> mos. <u>12</u> ds. | | | |
| (Signed) <u>D. J. Long</u> , M. D. , 191 (Address) <u>Piedmont, W. Va.</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>12</u> mos. <u>12</u> ds. In the State <u>1</u> yrs. <u>12</u> mos. <u>12</u> ds. Where was disease contracted, If not at place of death? Former or usual residence. | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Weston - Ind -</u> | | DATE OF BURIAL <u>June 19, 1914</u> | |
| 20 UNDERTAKER <u>August E. E. E.</u> | | ADDRESS <u>Weston, Ind.</u> | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

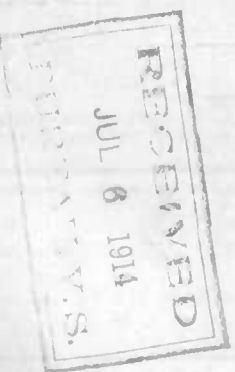
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms of terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

5470

County AlleganySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2Village or City Twigg town (No. _____) St.; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary A Twigg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)

6 DATE OF BIRTH May 6, 1883
(Month) (Day) (Year)

7 AGE 91 yrs. 27 mos. 27 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) md

PARENTS
10 NAME OF FATHER Joyd Staicing
11 BIRTHPLACE OF FATHER (State or country) md
12 MAIDEN NAME OF MOTHER Rachal Robinson
13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. P. Twigg(Address) Twigg town

15 Filed June 3, 1914 D. Bennett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1914, to June 2, 1914,
that I last saw her alive on June 2, 1914.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. P. Twigg, M. D.

June 3, 1914 (Address) Twigg town

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Twigg town DATE OF BURIAL June 4, 1914

20 UNDERTAKER J. C. Wolford ADDRESS Cumberland

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

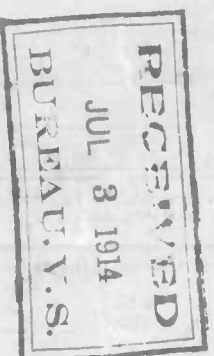
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

5471

County

Allegheny

Village or City

Uniontown (No. 1 Allegheny St.)

Registration Dist. No.

4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

B. P. Vanverth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

June 24, 1898
(Month) (Day) (Year)

7 AGE

5.5 yrs. 11 mos. 9 ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Preston Co. W. Va.

10 NAME OF FATHER

John Vanverth

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Saucer

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clyde Vanverth

(Address)

Merritt Sta.15 JUN 4 1914
Filed

101

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 3, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 28, 1914 to June 3, 1914.that I last saw him alive on June 3, 1914.and that death occurred on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cancer of StomachPost Operative (Duration) 1 yrs. 1 mos. 1 ds.

Contributory Secondary

Uremia(Duration) 2 1/2 yrs. 2 mos. 2 ds.(Signed) E. B. Claybrook, M. D.June 4, 1914. (Address) 61 Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.Where was disease contracted, Terra Alta W. Va.

If not at place of death?

Former or usual residence Terra Alta

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Paul's Church, Terra Alta, W. Va. June 4, 1914

20 UNDERTAKER

ADDRESS

W. B. Butler, 29 N. Centre

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

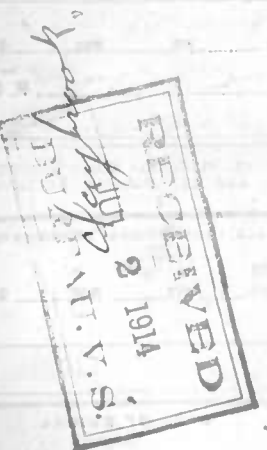
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| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH 5472 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Allegany</u> | | Registration Dist. No. <u>4</u> | |
| Village or City <u>Cumberland</u> (No. <u>Alleg. Hosp.</u> St.; Ward) | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| 2 FULL NAME <u>John Walters</u> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word) | |
| 6 DATE OF BIRTH — — — 1864 (Month) (Day) (Year) | | | |
| 7 AGE 50 yrs — mos — ds. OR LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Blacksmith</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Mining Co.</u> | | | |
| 9 BIRTHPLACE (State or country) <u>md</u> | | | |
| PARENTS | 10 NAME OF FATHER <u>Unknown</u> | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>"</u> | | |
| | 12 MAIDEN NAME OF MOTHER <u>"</u> | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>"</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>C. F. Walters</u> (Address) <u>Box 24</u> | | | |
| 15 JUL 2 1914 Filed <u>July 1, 1914</u> <u>Joseph R. Dand</u> REGISTRAR | | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH <u>June 30</u> , 1914 (Month) (Day) (Year) | | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 30</u> , 1914, to <u>June 30</u> , 1914, that I last saw him alive on <u>June 30</u> , 1914, and that death occurred on the date stated above, at <u>4:30</u> m. | | | |
| The CAUSE OF DEATH* was as follows: <u>Crushed legs by railroad train</u> <u>hemorrhage.</u> (Duration) — yrs. — mos. — ds. | | | |
| Contributory Secondary (Duration) — yrs. — mos. — ds. | | | |
| (Signed) <u>J. H. Spicer</u> , M. D. <u>July 1, 1914</u> (Address) <u>Cumberland Md</u> | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. <u>3 hrs</u> In the State — yrs. — mos. — ds. <u>3 hrs</u> Where was disease contracted, <u>Blaine N. H.</u> If not at place of death? Former or usual residence <u>Blaine N. H.</u> | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Blaine N. H.</u> DATE OF BURIAL <u>July 2, 1914</u> | | | |
| 20 UNDERTAKER <u>Louis Stem</u> ADDRESS <u>City.</u> | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

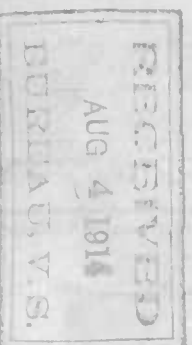
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Sclie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH | | 5473 (63) | |
| County | | Allegheny | |
| Village or City | | Westport (No.) St.; Ward) | |
| 2 FULL NAME | | Raymond Whelan | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | |
| Male | White | Single | |
| 6 DATE OF BIRTH | March 11, 1913 (Month) (Day) (Year) | | |
| 7 AGE | 1 yrs. 2 mos. 19 ds. OR LESS than 1 day, hrs. OR min. ? | | |
| 8 OCCUPATION | (a) Trade, profession, or particular kind of work. none | | |
| | (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) | Westport Md | | |
| PARENTS | 10 NAME OF FATHER | Thos J Whelan | |
| | 11 BIRTHPLACE OF FATHER (State or country) | Jamesville Ohio | |
| | 12 MAIDEN NAME OF MOTHER | Leanna McKeone | |
| | 13 BIRTHPLACE OF MOTHER (State or country) | Westport | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| (Informant) Margaret Whelan | | | |
| (Address) Jamesville Ohio | | | |
| 15 Filed | 6/3-1914 | | |
| | REGISTRAR | | |
| MEDICAL CERTIFICATE OF DEATH | | | |
| 16 DATE OF DEATH June 2 nd , 1914 (Month) (Day) (Year) | | | |
| I HEREBY CERTIFY, That I attended deceased from May 13, 1914, to June 2, 1914, that I last saw him alive on June 2, 1914, and that death occurred on the date stated above, at 1 P. M. | | | |
| The CAUSE OF DEATH* was as follows: Infantile Paralysis | | | |
| (Duration) yrs. mos. 22 ds. | | | |
| Contributory Secondary | | | |
| (Signed) E. J. Pearson M. D. | | | |
| June 3, 1914 (Address) Redman Md | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | | | |
| At place of death yrs. mos. ds. In the State yrs. mos. ds. | | | |
| Where was disease contracted, If not at place of death? Former or usual residence | | | |
| 19 PLACE OF BURIAL OR REMOVAL | | DATE OF BURIAL | |
| Westport Md | | June 4, 1914 | |
| 20 UNDERTAKER | | ADDRESS | |
| E. J. Pearson | | Chilman 117 | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

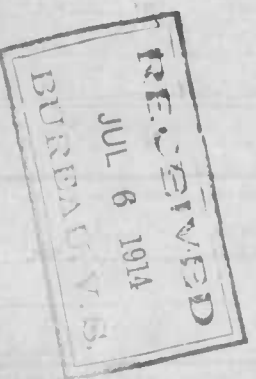
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5474

(64)

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty AlleganyRegistration Dist. No. 7Village or City Westport (No. Vine & Johnson St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Franklin Whitman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)widower

6 DATE OF BIRTH

March 4 1884
3 (Month) 4 (Day) 1884 (Year)

7 AGE

67 yrs. 3 mos. 3 ds. OR LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Grocery Business

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Virginia
Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Lillard

(Address)

Westport Md.

15

Filed

June 7 1914
W. E. Lillard
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 25, 1914 to June 7, 1914that I last saw him alive on June 7, 1914and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Removal of Brain

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 7, 1914 (Address) Westport Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pellae - OhioJune 9, 1914

20 UNDERTAKER

ADDRESS

Mr. Fred CookWestport Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

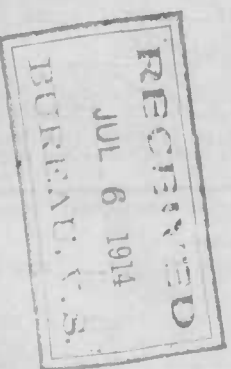
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5475

County

Allegheny

Village or City

Frinting (No. 17)

Registration Dist. No.

9

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE Col. 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

6 18 1914
(Month) (Day) (Year)

7 AGE

It LESS than
1 day, ____ hrs.
____ yrs. ____ mos. ____ ds. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Frinting

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

Ellen Williams

13 BIRTHPLACE OF MOTHER (State or country)

Frinting

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benj. Williams

(Address)

Frinting

15

Filed June 18, 1914 D. L. Conroy
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6 18 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

on June 18th, 1914.

that I last saw h. alive on April 1st, 1914and that death occurred on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. C. Cohen, M. D.June 18, 1914 (Address) Frinting

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Allegheny Cern. June 18, 1914

20 UNDERTAKER

ADDRESS

None

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

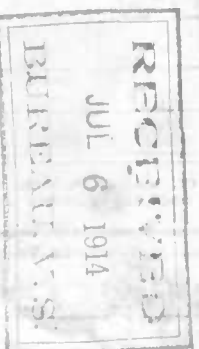
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | | | | | |
|---|--|--|--|---------------------------------------|--|---|--|
| 1 PLACE OF DEATH | | 5476 | | 108 | | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| County <u>Allegheny</u> | | Village or City <u>Cumberland</u> | | (No. <u>Allegheny Hosp</u> St.; Ward) | | Registration Dist. No. <u>4</u> | |
| 2 FULL NAME <u>John Stewart Wilson</u> | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | | | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write in full) <u>Married</u> | | | | | |
| 6 DATE OF BIRTH <u>Jan 17, 1865</u> (Month) (Day) (Year) | | 7 AGE <u>49</u> yrs. <u>5</u> mos. <u>4</u> ds. If LESS than 1 day, hrs. OR min. ? | | | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Mechanic</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>B & O</u> | | | | | | | |
| 9 BIRTHPLACE (State or country) <u>Pa</u> | | | | | | | |
| PARENTS | 10 NAME OF FATHER <u>Jackson Wilson</u> | | | | | | |
| | 11 BIRTHPLACE OF FATHER (State or country) <u>Pa</u> | | | | | | |
| | 12 MAIDEN NAME OF MOTHER <u>Don't know</u> | | | | | | |
| | 13 BIRTHPLACE OF MOTHER (State or country) <u>—</u> | | | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Gladis May Wilson</u> (Address) <u>216 Ave. Hotel</u> | | | | | | | |
| 15 <u>JUN 22 1914</u> Filed <u>1914</u> | | 16 DATE OF DEATH <u>June 21, 1914</u> (Month) (Day) (Year) | | | | | |
| 17 | | I HEREBY CERTIFY, That I attended deceased from <u>June 21, 1914</u> , to <u>June 21, 1914</u> , that I last saw him alive on <u>June 21, 1914</u> , and that death occurred on the date stated above, at <u>1 P.</u> m. | | | | | |
| The CAUSE OF DEATH* was as follows: <u>Past operative Intermittent Absorption & Shock</u> (Duration) yrs. mos. <u>3</u> ds. | | | | | | | |
| Contributory <u>Acute appendicitis</u> Secondary (Duration) yrs. mos. <u>8</u> ds. | | | | | | | |
| (Signed) <u>E. B. Cefay</u> M. D. <u>June 21, 1914</u> (Address) <u>Cumberland, Md</u> | | | | | | | |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | | | | | |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. <u>5</u> ds. In the State yrs. mos. ds. <u>Don't know</u> | | | | | | | |
| Where was disease contracted, If not at place of death? <u>City of Cumberland</u> | | | | | | | |
| Former or usual residence <u>City of Cumberland</u> | | | | | | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Altoona Pa</u> | | | | DATE OF BURIAL <u>June 22, 1914</u> | | | |
| 20 UNDERTAKER <u>Louis Stem</u> | | | | ADDRESS <u>City</u> | | | |
| REGISTRAR <u>Joseph A. David</u> | | | | | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Penne R R

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

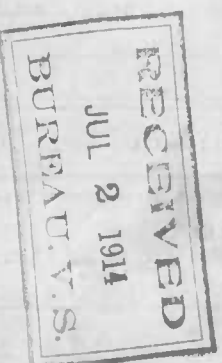
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

5477

County

Allegheny

Village or City

Westonport

(No.

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John T. Lais

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

Sept

10

1842

(Month)

(Day)

(Year)

7 AGE

77

yrs.

8

mos.

23

ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

West Va

PARENTS

10 NAME OF FATHER

Dmt. Lais

11 BIRTHPLACE OF FATHER (State or country)

Dmt. Lais

12 MAIDEN NAME OF MOTHER

Dmt. Lais

13 BIRTHPLACE OF MOTHER (State or country)

Dmt. Lais

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Lais

(Address)

Westonport, Md

15

Filed

June 3, 1914

H. W. Proffitt

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June

3

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr 2, 1914, to

June 2, 1914

that I last saw him alive on

June 2, 1914

and that death occurred on the date stated above, at

39 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of bladder

(Duration)

yrs.

6

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. W. Proffitt

M. D.

June 3, 1914

(Address)

Westonport, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Public Westonport, Md

June 3, 1914

20 UNDERTAKER

ADDRESS

W. H. Proffitt

Friedman

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[Approved by U. S. Census and American Public Health Association.]

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